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Vol. 33 FEBRUARY, 1953 No. 2

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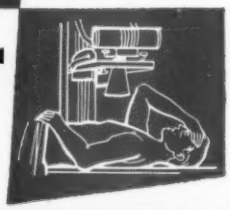

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The Manitoba Medical Review

Vol. 33 . FEBRUARY, 1953 No. 2

Surgery

Common Ano-Rectal Lesions Diagnosis and Treatment*

S. S. Peikoff
M.D., F.R.C.S. (Edin.), F.R.C.S. (C) F.A.C.S.

Ano-rectal lesions are of the greatest importance not only to the general practitioner, but equally so to the internist and surgeon for several reasons:

Firstly because pathological lesions are extremely common in this area. Almost every person over fifty years of age has some form of ano-rectal pathology. If these lesions are not diagnosed early and treated properly, they may become tragically disabling.

Secondly, for some reason or other, physical examination of the lower bowel appears to be neglected more than any other part of the body. There is a tendency on the part of physicians to disregard symptoms of this area or perhaps treat them lightly as being of minor importance.

Thirdly, either from embarrassment or modesty, the patient is reluctant to consult his doctor early in the progress of the disease. He postpones and delays and usually resorts to ointments or suppositories purchased at a local drug store, with the result that he consults his physician late in the progress of the disease. If now the doctor assumes a careless attitude, he may miss a curable pre-malignant lesion or an early operable malignancy and thus condemn the patient to a colostomy life or that of a hopeless invalid.

At this point a fleeting review of the embryology and anatomy of this region will help to assess the clinical applications more readily.

Fig. 1. During the fifth week of intra-uterine life, a band of mesoderm (Rathke's septum) grows down from the region of the allantois and splits the lower bowel into the urogenital sinus and the hind gut, giving them a common opening, the cloaca.

Fig. 2. The septum continues downwards until it abuts on the cloacal membrane separating the bowel completely from the urogenital sinus. The cloacal membrane now rests against the skin and is divided into the urogenital membrane and the anal membrane. At the same time a small dimple forms in the skin over the anal membrane, producing the proctodeum.

Fig. 3. At the eighth week the bowel becomes canalized from above downwards. The anal membrane ruptures so that the proctodeum and rectum join at the ano-rectal line.

If this development is retarded in any phase several important practical anomalies will result:

1. Congenital Anal Stenosis. Incomplete rupture of the anal membrane will result in congenital stenosis or stricture (Fig. 4). This is a very important clinical condition which occurs very frequently in infants, anywhere from 35 to 50%. This usually corrects itself in about three to six months, but reports show conclusively that in 12 to 25% of infants, there is a palpable ano-rectal ring composed of mucosa and submucosa from ¾ to 1¼ inches above the anus. The infant strains and cries during defaecation, turns red or blue in the face, and sometimes has ribbon stools. This condition can usually be corrected by gentle dilatation with graduated dilators or the finger.

2. Imperforate Anus. Where the anal membrane is completely intact and fails to rupture (Fig. 2).

3. Absence of the Rectum (Fig. 5). The bowel may fail to canalize and the lower inch or two of the rectum is completely absent. It is important to know as soon as the baby is born whether this is a case of imperforate anus or if a part of the bowel is absent. In the case of an imperforate anus, the anal membrane can readily be broken down with a pair of artery forceps. Where, however, the bowel is absent, a temporary colostomy must be performed. In order to determine the amount of bowel absent, Wagensteen has evolved a simple radiological manoeuvre. By placing a penny on the anal dimple and suspending the infant in an inverted position, an X-ray is taken. The distance between the gas in the bowel and the penny determines the amount of rectum absent.

4. Fistulae (Fig. 6). If Rathke's septum fails to grow down to the cloacal membrane, various fistulae will result—recto-vaginal, recto-vesical, or recto-urethral fistulae.

Anatomy (Fig. 7)

When the anal membrane ruptures, the rectum now communicates with the anus at the ano-rectal junction or pectinate line, so-called because it resembles a cock's comb. This is a sort of international boundary. The hind gut is formed of entoderm while the anus is formed of skin, so that at this boundary line, they are fundamentally different in their pathology and anatomy.

1. Mucosa. The mucosa is lined by columnar epithelium and is thrown into a series of longitudinal folds forming the columns of Morgagni.

*Presented at the Annual Meeting of the Manitoba Medical Association, Winnipeg, October 8th, 1952.

They are about half an inch long and very vascular. The bases of these columns are connected by small transverse semi-lunar folds—the anal valves. Just above these folds the mucosa is slightly depressed to form the crypts of Morgagni. These crypts contain long racemose glands which secrete mucus which lubricates the stool in its passage. These as we shall see, have a great clinical significance. At the apex of each valve, there is a small triangular projection called the papilla.

Skin. The anus is lined with modified skin containing sweat glands and hair follicles.

2. Blood Supply: Arteries—1. Superior haemorrhoidal artery. 2. Middle haemorrhoidal artery. 3. Inferior haemorrhoidal artery.

Veins—1. The superior haemorrhoidal vein begins as a plexus at the ano-rectal line, pierces the muscle wall, passes straight upwards to join the splenic vein at right angles and thus empties into the portal circulation. These veins are long, have no valves, and since they pierce the muscle, are subject to compression by a constipated stool. With this set-up it is amazing that the majority of humans are not afflicted with haemorrhoids.

2. The inferior haemorrhoidal vein commences as a plexus just below the ano-rectal line, drains into the internal pudendal and so to the systemic system. Therefore at the ano-rectal line, there is an anastomosis between the portal and systemic systems and any enlargement of the liver, whether due to diseases of the heart or neoplasm, there will be a back pressure in the venous system with an increase in the incidence of haemorrhoids.

The Lymphatics. Above the ano-rectal line the lymphatics drain along the superior and middle haemorrhoidal vessels to the hypogastric and lumbar glands, so that in malignancy of the rectum, either of these two sets of glands are involved.

Below the ano-rectal line the lymphatics of the skin of the anus drain along the inferior haemorrhoidal artery to the internal pudendal artery to the inguinal glands and infection or malignancy anywhere in the area of the anal region will involve the inguinal glands.

4. The Nerves. The rectum is supplied by the autonomic nervous system — sympathetic fibres from the presacral nerve and parasympathetic fibres S-2-3-4—analogous to the vagus nerve. For this reason the rectum is insensible to pain and one may cauterize it, cut or inject it without any pain.

The anal canal, however, is supplied by the cerebro-spinal nerves through the pudendal nerve and this area is extremely sensitive to pain. Any lesion which encroaches on the pectinate line results in severe agonizing pain and spasm of the sphincter (which is also supplied by the pudendal nerve). If pain is a primary symptom one may assume that the lesion is below the pectinate line.

Symptomatology. The patient usually presents himself with one of five symptoms:

1. Bleeding is the commonest symptom. Bright red blood in the bowel or streaks of blood on the stool accompanied by severe shooting pain during defecation suggests anal fissure. On the other hand, spurts of bright red blood, and this may be large in amount, without pain, suggests haemorrhoids. Brown or black stools due to blood mixed with the feces indicates a lesion high up in the colon.

2. Swelling. Thrombosed haemorrhoid or new growth.

3. Pain suggests fissure, abscess, cryptitis, papillitis.

4. Discharge—mucus or pus.

5. Itchiness—pruritis ani.

It goes without saying that an accurate and detailed history relating to the particular complaint is most important if one wishes to formulate a hypothesis as to the nature of the pathology or the site of the lesion.

Examination. The examination consists of: 1. Inspection. 2. Palpation. 3. Proctoscopic examination. 4. Sigmoidoscopic examination. 5. Biopsy. 6. Barium Enema. 7. Contrast Enema.

Inspection. Examination must be systematic in order that nothing be missed. An enema is not essential at the first examination. The patient is placed in one of three positions. 1. either the inverted position on a special table which costs from $600 to $1,000; is reserved only for specialists and is unnecessary; 2. the left lateral or Sim's position; 3. the knee-chest position. I prefer the latter two, and use them as the occasion demands. It is important to have a good light. In my office I have an adjustable bracket attached to the wall just over the centre of the table so that it can be manouvered into any position; but a good flashlight serves the purpose just as well.

On inspection: 1. Pilonidal sinus—one may see a depressed dimple or sinus, or reddened area just above the base of the coccyx which may indicate the presence of a pilonidal sinus.

2. A peri-anal haematoma. This is a thrombosis of one of the subcutaneous veins from the inferior haemorrhoidal. There is a bluish, hard, painful swelling which comes on acutely. It may subside in two or three weeks, or may become abscessed. Inject a little local anaesthetic, make an elliptical incision, and express the clot. No stitches are necessary. Patient takes hot sitz baths at home. Excision shortens the convalescence.

3. Hypertrophiec skin tag—is really a fibrosed peri-anal haematoma which becomes dirty and itchy. Inject a little local anaesthetic, snip off

EMBRYOLOGY

Fig.I COMMON CLOACA
R-Rathke's Septum
A-Allantois
H.G.-Hind gut
U.R.-Urogenital Sinus

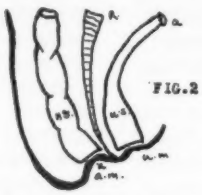


Fig.2 DIVISION OF CLOACA
A.M. Anal Membrane
U.M. Urogenital Membrane
Proctodeum forms (x)

Fig.3 CANALIZATION OF RECTUM
Rupture anal membrane
Anorectal junction

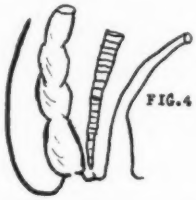


Fig.4 CONGENITAL ANAL STENOSIS

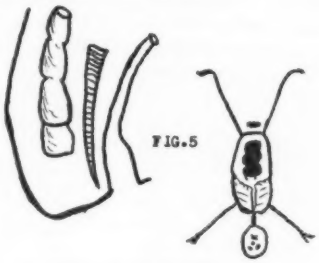
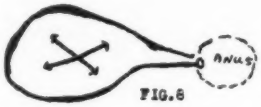
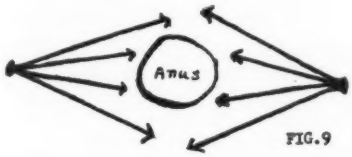
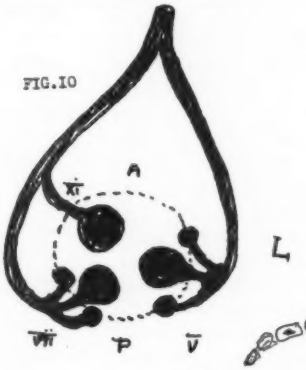


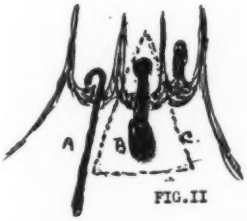
Fig.5 ABSENCE OF RECTUM
Failure of canalization

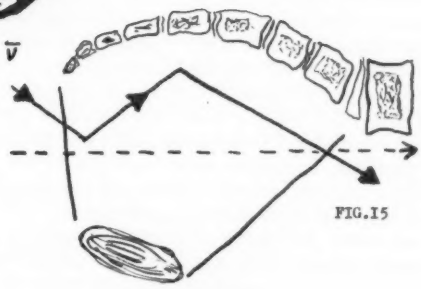
Fig.6 FISTULAE
Incomplete septum











with scissors and touch up with silver nitrate stick.

4. Ischio-rectal abscess (Fig. 8). There may be a slight bulging or redness with induration or even fluctuation. This must never be treated conservatively with hot fomentations, since the infecting organisms are usually associated with anaerobes which produce gas in a cavity of fat and fibrous trabeculae. The increased pressure along with the infection will produce wholesale destruction even overnight. It should be opened up immediately and the whole abscess laid open by a pear-shaped incision. If not too acute, the abscess should be traced to the original source, which is usually an opening in an infected crypt. If there is an internal opening, and it is not laid open, a fistula in ano may result.

5. Condylomatous patches — may be found around the peri-anal region and can be treated quite readily with applications of podophyllin 25 per cent suspension in mineral oil. They usually disappear after about four days, often after a single application.

6. Prolapse—One may notice a prolapse of the rectum and it may be difficult to distinguish from prolapsed haemorrhoids. A prolapse may be missed unless the patient is asked to strain.

7. Pruritis Ani—The skin around the anus is thrown into numerous oedematous pale folds and there is evidence of scratch marks. It is a very distressing and progressive condition. There are at least 50 possible causes ranging from allergy to neurosis, and more recently, a complication of anti-biotics. There are about 200 known cures. The worst feature is the uncontrollable itching, which leads to scratch infections in the deep cracks between two adjacent areas of oedematous skin. Mucus and fecal material run down these gutters and lend an ideal medium for infection. Medical treatment consists in correcting any organic conditions, and local hygiene is most important. I have found Rectalgan (Dohow Chemical Co.) most useful in controlling pruritis of moderate degree. In severe and intractable chronic cases some form of undercutting operation may be tried, such as Ball's operation. Recently tattooing with mercuric sulphide has given fair results. Personally I have found peri-anal alcohol injections to give good results. Under general anaesthesia the index finger of the left hand is introduced into the rectum and kept there as a guide. With the right hand 20 ccs. of 40 per cent alcohol is introduced through a small puncture incision 1½ inches from the anus and guided subcutaneously almost to the finger in the rectum. Introduce the solution as you withdraw the needle and thus prevent necrosis of the skin, although a slough is of no importance. The needle is re-introduced in a fan-shaped manner through the one stab incision on each side as shown in the diagram (Fig. 9).

8. External Fistulous opening may be palpated.

9. Imperforate Anus.

10. Tumors—lipoma, malanoma, epidermoid, cancer, may be found on inspection.

Several years ago I presented a case at the Tumor Clinic of a patient who came into the office requesting ointment for itching in the peri-anal region. (Fig. 16). I insisted on seeing the rash before I prescribed the ointment. To my surprise, I found an ulcerating carcinoma about an inch and a half in diameter, with the inguinal glands involved. This was excised, the glands on both sides dissected out. He is still alive and well, 6 years later. I merely present this case to show how insignificant this lesion appeared to the patient.

Palpation

A proper digital examination is most important. It is important to use a lot of lubricant. Explain to the patient that you will try to be gentle and not hurt him. This will go a long way to encourage him to relax his sphincter. I will never forget my experience of 5 years ago when I fell downstairs and hurt my coccyx. I made the unfortunate mistake of consulting an orthopedic surgeon for an examination. When he rammed his finger up my rectum I not only saw stars but I also saw an old aunt from Cincinnati whom I hadn't seen for 20 years. This type of examination will lose the patient for you. If you hurt him he will not return for any further treatment. If he has a sentinel pile which indicates a fissure, don't examine him without a little local infiltration or application of a swab soaked in 10% cocaine, since fistulae are extremely painful.

While palpating keep in mind the anatomical structures in that region.

1. The prostate, seminal vesicles, and the cervix of the uterus.

2. The tone of the sphincter—spasm or relaxation.

3. A pedunculated polyp.

4. Oleoma—a swelling resulting from a previous injection of phenol in oil given for haemorrhoids.

5. Haemorrhoids—cannot be felt unless thrombosed.

6. Stricture—post-operative, lymphogranuloma inguinali, congenital anal stenosis.

7. Fecal impaction in older people.

8. Foreign body—piece of fish bone or chicken bone, etc.

9. Blumer's shelf—secondary implantation of Ca cells of stomach, ovary or lower bowel.

10. Frozen pelvis — extension of cervical or uterine Ca.

11. Carcinoma—and here it is most important to examine all quadrants of the rectum—anterior, posterior, right and left. Cancer of the rectum can be diagnosed with the finger in 65% of cases. The patient should be examined in Sim's position since in a knee-chest position the growth tends to fall away from the finger. It is sad to state that in spite of all the literature and warnings and teachings, patients frequently undergo treatment for haemorrhoids when only an inch above the anus there lingers a carcinomatous growth. Carcinoma of the rectum, unlike carcinoma of the stomach, is considered a curable disease.

To prove my point, I would like to present a case, and there are many more like it, of a patient who was bleeding from the rectum for some time. It is claimed that it takes 1 year for a malignant growth to encircle the bowel. In this case the growth encircled ¾ of the circumference of the bowel. From the history one can assume that the

first 3 months were symptomless. The second 3 months when the lesion became ulcerated and bled, the patient was treated with suppositories and ointments by a druggist. The third 3 months the physician gave him injections for "bleeding piles." The growth was within easy reach of the finger and the patient could have had surgical interference long before it reached a Duke's 4, and became inoperable (Fig. 17). If the lesion involves the wall of the rectum alone during the first six months the percentage of cure is approximately 85%, whereas after this period, if even one gland is involved, the prognosis is reduced to 15%.

Proctoscopic Examination

Never do a proctoscopic examination without a previous digital examination since there may be present an unsuspected stricture or an obstructing mass. A fenestrated anoscope with an obturator is used to view lesions above the ano-rectal line: the common types are, the Hirschman, Brinkerhoff or Ives speculum, according to individual preference. The following clinical conditions can be investigated with a proctoscope:

1. Haemorrhoids. To examine haemorrhoids you must use the Sim's position since the knee-chest position empties the veins and the anoscope blanches them still further and they are kept emptied by the inverted position. Having asked the patient to lie on his side, the anoscope is introduced and as it is slowly withdrawn you ask him to strain and the haemorrhoids will appear distended in the slot. The position and number of piles are usually constant. The superior haemorrhoidal artery divides into a right and left branch (Fig. 10). The left ends at 5 o'clock. The right subdivides again into 2 branches, one at 7 o'clock and one at 11. There are therefore 3 major piles. The left and right posterior subdivide still further, producing 4 secondary haemorrhoids, so that there are altogether 7 haemorrhoids. In the early cases where bleeding is the sole symptom, injection treatment may be used. The percentage of cures is small. I use 5% phenol in almond oil to inject into the loose tissue of the submucosa above the haemorrhoid, to promote sclerosis. In more chronic cases surgery gives the best result. I prefer the Milligan operation which removes the entire pile-bearing area and anchors the stump to the longitudinal muscle of the rectal wall and so obviates retraction and fissure formation. Many methods may be used, providing certain principles are adhered to. You must leave an area of skin between each pile to prevent stricture formation. You may sew the mucosa but not the skin if you wish to avoid oedematous tags. Remove all unnecessary skin tags. In long standing cases with venous stasis, there is a good deal of fibrosis creating a fibrous band just under the anal skin referred to as the pecten band. This should be divided posteriorly at right angles until it is smooth, even if the muscle fibre of the sphincter must be cut.

Some surgeons inject proctocain in oil post-operatively to abolish pain. This has been definitely shown to cause oedema and fibrosis and to retard healing and produce scar formation. Clean-cut surgery with good pre- and post-operative care will obviate its use. Post-operative care is most important. To do a haemorrhoidectomy and discharge the patient without subsequent care is similar to placing a cast on a fractured arm for several weeks without observation only to find a Volkmann's contracture. The post-operative care of ano-rectal wounds fundamentally is to keep them open to prevent bridging of the skin and promote drainage.

2. Cryptitis—As a result of constipation the crypts become deeper and deeper until they resemble a vest pocket. Stagnation of feces in these pockets leads to infection of the mucous glands with abscess formation resulting in pain and spasm. Bend a probe in the form of a hook, and insert the hook into the crypt and excise the edges around it. This promotes drainage and gives relief. If there is considerable spasm, the sphincter may be cut posteriorly (Fig. 11A).

3. Papillitis—This is a triangular projection from the anal valves at the base of the columns of Morgagni (Fig. 11C). From constipation or irritation it may become hypertrophied and may range in size from a finger tip to a hen's egg; and may even be extruded from the anus. When they are small they may be snipped off with a pair of scissors, while in the larger ones the pedicle should be ligated.

4. Fissure—Fissure in ano is an ulcer of the anal canal beginning as an infection in a crypt. The abscess is torn open by a constipated stool. The papilla on the anal valve increases in size as the result of blocked lymphatics, becomes oedematous and is termed the internal sentinel pile. At the lower end the skin becomes slightly oedematous forming the external sentinel pile (Fig. 11B). 95% of the ulcers occur on the posterior aspect of the anus. This is due to the fact that the coccygeus muscle arises from the sides of the coccyx so that the mucosa overlying the bony coccyx at this point is not cushioned with muscle (Fig. 12). In addition, at this point the anus forms an acute angle with the rectum, and is vulnerable to trauma in this area by a constipated stool (Fig. 13). Digital exploration is impossible on account of pain or spasm. One can see the lower end of the fissure by pulling the buttocks apart gently. In chronic cases surgery is the only treatment. Excise the entire fissure in the form of a triangle whose sides are 1 inch, including the internal and external sentinel pile (Fig. 11B). If there is a firm

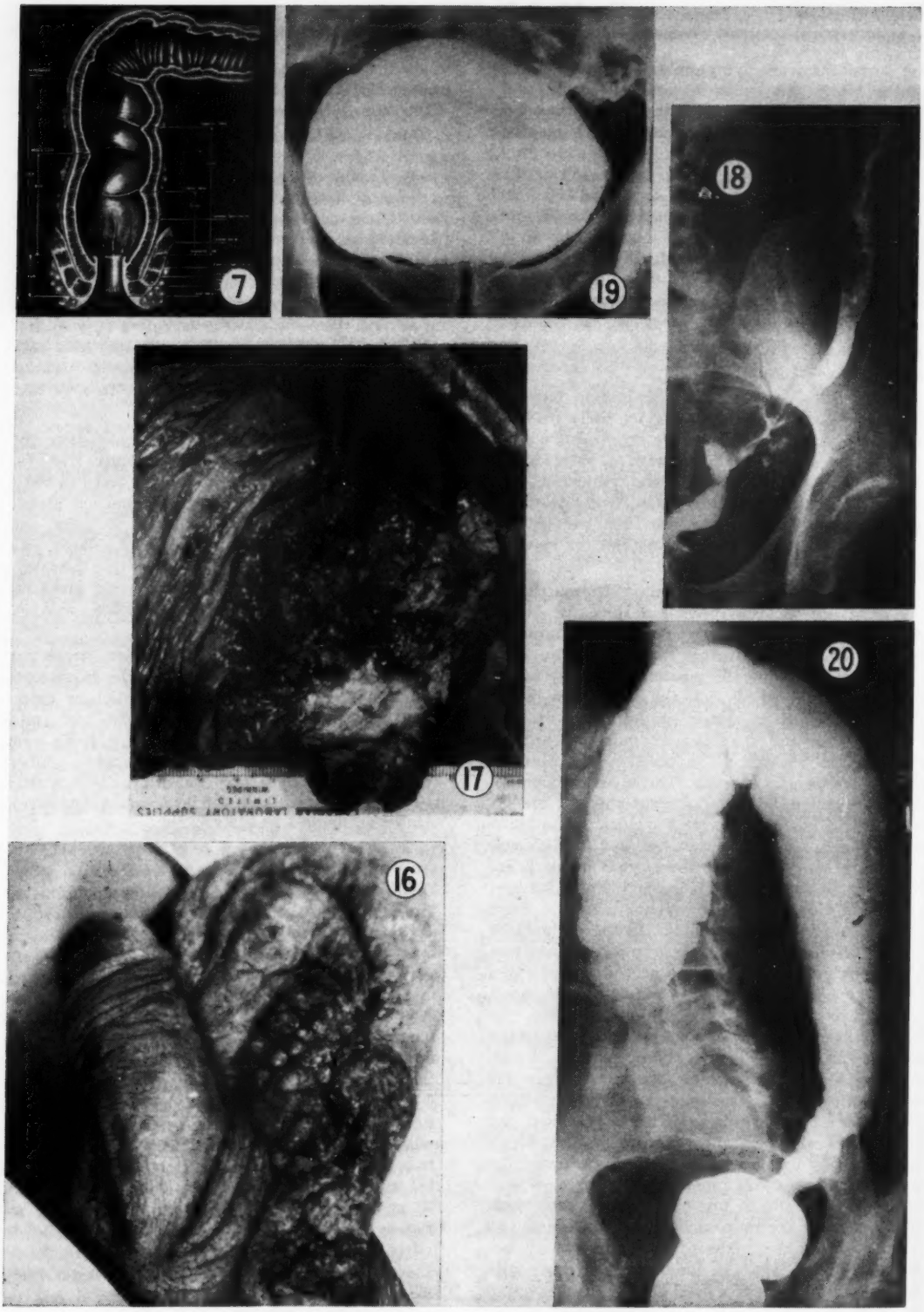


Illustration of Fig. 7 Courtesy of Doho Chemical Co. Inc.

transverse projecting band at the base of the wound incise this longitudinally and posteriorly. Do not remove any piles at the same sitting, as there may be danger of stricture. Be sure to massage and dilate the anus every 3 or 4 days in order to prevent bridging and promote drainage.

5. Fistulo in ano—Fistulo in ano is a communication between the anus and the skin. It begins as an abscess in a crypt—cryptitis. Infection travels deeply between the two parts of the external sphincter and points at the skin. Goodsall has formulated a law to locate these openings (Fig. 14). If the external opening is anterior to an imaginery transverse line of the anus the internal opening is opposite to it. If the external opening is posterior to this tranverse line, the internal opening is posterior. To locate the fistula pass a probe from the skin towards the anus as indicated so that the probe protrudes through the internal opening. Pull forwards on the probe and excise the entire tract around it with a liberal amount of skin, laying it open completely from the internal to the external opening. The sphincter fibres may be cut at right angles, providing they are cut at only one point. Post-operative care consists of frequent dilatations to prevent the skin from bridging over. Failure to dilate or massage every 3 or 4 days results in recurrence.

Sigmoidoscopic Examination

To do a proper sigmoidoscopic examination the lower bowel must be clean. I furnish my patient with a hot water bottle and an attachment in the office. He goes to the men's room and washes out the lower bowel 3 or 4 times and returns for examination. This is much more satisfactory than if he is given a cathartic at bedtime and an enema in the morning, since after several enemas the mucosa becomes so congested that one cannot distinguish it from that of mucus colitis. Before commencing the examination warn the patient that he will have a feeling that his bowels are going to move when the instrument is introduced, but the bowel will not function since it is empty. If this warning is not given he will be embarrassed, strain, and will make the examination difficult or impossible. It is important to pass the instrument completely at the first sitting and examine the bowel as the instrument is withdrawn, since too much time consumed in introducing the instrument will tax the patient to the point of refusal to complete the examination. On pulling out the sigmoidoscope, it should be rotated so that the entire circumference of the bowel is inspected. The examination is usually easily done, but it is important to remember also that 5% of patients cannot be sigmoidoscoped on account of a very marked promontory of the sacrum or a very short meso-sigmoid. In these cases, one should not persist since overdistension by inflation may easily perforate the bowel. The patient is examined in the knee-chest position. The first step is to pass the sigmoidoscope in the direction towards the umbilicus. The instrument is then lowered so that the distal end follows along the hollow of the sacrum. Continue to pass the sigmoidoscope and at the same time gently inflate the bowel. Try to view under direct vision Houston's valves and all the elevations and crevices as if you are touring Carlsbad caverns. Finally, rotate the sigmoidoscope forwards to pass over the promontory of the sacrum (Fig. 15).

The following clinical conditions may be seen:

1. Ulcerative colitis—multiple bleeding ulcers covered with pus and mucus.

2. Amoebic ulcers — typically punched-out bleeding ulcers.

3. Bacillary dysentery with superficial ulcers in a red and bleeding mucosa.

4. T.B. ulcers at any level with irregular overhanging edges.

5. Polyps or adenomas which should always be considered pre-malignant.

6. Carcinoma—This is the most important condition of all. Any patient who bleeds per rectum must be considered a case of malignancy unless proven otherwise. The radiologist cannot give you any information on lesions located between the ano-rectal and the recto-sigmoid junction. It is the entire responsibility of the sigmoidoscopist to pick out any lesions in this area. Therefore, whatever you cannot reach with your finger you must find with the sigmoidoscope.

Biopsy

A biopsy should be done of all lesions which look suspicious. Failure to do so may result in medico-legal complications and tragic results.

To condemn a patient to a colostomy life or a verdict of inoperable carcinoma without a biopsy is a criminal offence. The case herewith is an example of this type of indiscretion.

In 1946 a patient presented himself at my office with a permanent colostomy. He informed me that he had obstruction of the bowels in 1940, was explored, and the surgeon told him that he had a growth which could not be removed. Apparently after some coaxing he prevailed on his surgeon to tell him the truth. Whereupon the surgeon informed him that his growth could not be removed but that now he could continue living comfortably anywhere from 6 months to 2 years. This man disposed of his estate and retreated to the woods as a hermit. No longer could he meet his friends in the beer parlor or in company for fear of a gush of foul gas at unpredictable times. On investigation, a Barium enema (Fig. 18) revealed a normal upper colon and sigmoidoscopic examination revealed a normal lower colon. I attempted to convince him that closure of the colostomy would re-establish his normal bowel habit. Once bitten, twice shy; he refused and returned to

his hermit's life.

In 1948 he was referred to me by another physician for severe and agonizing dysuria. A Barium enema revealed a colo-vesical fistula (Fig. 19). He now consented to operation.

After adequate preoperative preparation e.g., anti-biotics, re-establishment of protein and fluid balance, the patient was explored. The descending colon presented advanced diverticulitis. The fistula into the urinary bladder was excised and the opening closed; the diseased portion of the colon resected; the colostomy excised; and the transverse colon anastamosed to the rectum so that the normal intestinal continuity was re-established.

For ten years this man lived a life of terror—simply because his surgeon did not do a sigmoidoscopic examination or biopsy. He condemned him to a hopeless and insecure life without confirmation. (Fig. 20 — Reconstructed anastomosis 10 weeks later).

Conclusion

In conclusion I would like to plead with the physician to respect ano-rectal symptoms. A careful history along with a systematic routine examination which includes inspection, palpation, sigmoidoscopic examination, biopsy, barium and contrast enemas should be done in all cases where bleeding is a symptom. A little more attention should be given to post-operative care in ano-rectal surgery in order to avoid recurrent fissures and post-operative strictures. Use your finger as often as your stethoscope, and you will reduce the number of patients destined to become hopeless invalids. Give them the chance of recovery which they deserve.

Medicine

*Has the Stethoscope Become an Obsolete Instrument?

John W. Scott, M.D.

The rather provocative title is meant to raise in one's mind the question as to the value of auscultation as a part of a general examination. Have the more modern methods of diagnoses which have evolved in the twentieth century replaced some of the nineteenth century and made auscultation an outmoded method of examination? Could we for instance save a great deal of the patient's time and our own by carrying out a radiological and E.C.G. examination of the chest on every patient in whom we suspect a chest lesion or heart lesion without the routine of a physical examination? This question came to one's mind when a colleague recently told of a distinguished radiologist in the United States who has a stethoscope exhibited in a glass case in his office with a descriptive card stating: "This now obsolete instrument was used by physicians in the late nineteenth and early twentieth centuries as a part of a crude method of examining the heart and lungs."

It is well to take stock periodically of the value of the procedures which we use in the everyday practice of medicine. This periodic assessment should apply to both diagnostic and therapeutic procedures.

Some of us are inclined to follow a pattern of thinking over the years which precludes the introduction and utilization of new diagnostic and therapeutic measures. On the other extreme some may be willing to throw overboard tried and proven diagnostic and therapeutic methods just because they are old. Those of us who teach medical students often hear the use of the older methods challenged. This is a rightful prerogative of youth and is a good thing. The wise man, however, knows that whether in the fields of medicine or politics or business that not all the new things are good and not all the good things are new.

The introduction of auscultation by Laennec in France in the early nineteenth century was very slowly accepted and did not come into general use in English speaking countries for thirty years. Stokes in Dublin and Hope in London were ardent advocates of the new art. Its use met with opposition as one might expect. The monaural stethoscope of Laennec was a crude affair compared with the twentieth century binaural instrument we use today.

Auscultation as a part of bedside diagnoses reached fruition in the golden age of clinical medicine about the middle of the last century. The medical giants of that era such as Stokes, Graves, Bright, Addison and Trousseau were keen observers at the bedside. They used every sense to good advantage seeing, smell, and taste including that of hearing. The nineteenth century physicians were concerned not so much with the discovery of the cause of disease as its recognition and the relation between physical signs at the bedside and morbid anatomical changes in the post-mortem room.

With the rapid strides of the later years of the nineteenth and the earlier years of the twentieth centuries in bacteriology, radiology, biochemistry, endocrinology and hematology, medicine took on a new look. The whole outlook of medicine became dynamic rather than static. The

*Presented at the Annual Meeting of the Manitoba Medical Association, Winnipeg, October 10th, 1952.

tempo of activity in the temple of Minerva was speeded up.

It was a natural outcome that we looked askance at some of the older concepts and older tools of our profession. Many of the physical signs in the chest which some of us laboriously learned forty years ago, are now forgotten and outmoded since the perfection of the chest radiography. How many of us today would recognize the tracheal tug of aortic aneurysm or D'Espine's sign of mediastinal lymph node enlargement. In spite of the value of newer diagnostic measures, I am sure we are all agreed that physical examination has a basic place in medicine and auscultation is of the greatest value.

It may be of interest to review some of the auscultatory findings that occur in a few common conditions in the cardio-vascular, respiratory, gastro-intestinal and nervous systems.

Cardio-vascular System

The early recognition of the failing heart by the physician is of the greatest importance. Our primary interest in the heart is centred around the fact that the heart sometimes fails and in so doing leads to disability or death. The early recognition of cardiac failure is the first step towards adequate treatment. It is worth noting that life expectancy in most patients with congestive heart failure who are adequately treated is considerably greater than in patients following radical treatment for cancer. Hence the importance of early recognition and treatment. Subjective enquiry rather than physical examination leads to early diagnosis of failure. Shortness of breath is easily the most important symptom. What would one expect to find in auscultation in the patient with cardiac failure? It is worthy of note that murmurs are frequently absent unless organic valvular disease or functional valvular insufficiency is present. The heart sounds may be normal but occasionally they are poorly heard. The first sound at the apex may be faint and the apical sounds may have a tic-tac quality. With left ventricular failure such as occurs with essential hypertension or aortic disease there is frequently heard gallop rhythm at the apex. The heart is often irregular in failure. The most significant irregularities are premature beats and auricular fibrillation. Accentuation of the pulmonic second sound is common in heart failure. Such a finding points to an increased pressure in the pulmonary circulation which is one of the concomitants of left ventricular failure. Auscultation of the lung bases shows basal crepitations in both right and left sided heart failure. This finding may precede the full blown picture of nocturnal dyspnoea as clinical evidence of acute pulmonary oedema in left ventricular failure. The finding of basal crepitations should alert the physician to institute treatment such as digitalization and the use of mercurial diuretics in the hope of averting the distressing occurrence of cardiac asthma.

Mitral Stenosis

Mitral stenosis is diagnosed largely on auscultatory findings with confirmation by radiological examination. The classical auscultatory finding is a rumbling mid-diastolic apical murmur, without propagation and a loud 1st sound. With the introduction and perfection of a surgical procedure for the treatment of this condition it is of increasing importance that mitral stenosis be recognized by the physician and that it be distinguished from mitral incompetence.

The mid-diastolic murmur of mitral stenosis is best heard when the patient is recumbent and in the left lateral position. It may be completely missed when the patient is seated or standing. One should use a bell chest piece on the stethoscope. As mitral stenosis becomes more marked the murmur tends to run up to the first heart sound and become pre-systolic. If auricular fibrillation or heart failure develops the pre-systolic part of the murmur becomes less prominent.

Can one exclude mitral insufficiency on auscultation before recommending a patient for mitral commisurotomy which now seems to have a place in the treatment of mitral stenosis? The physician will be asked more often in the future to make the decision as to the selection of patients for this operation.

The presence of a loud systolic apical murmur with evidence of left ventricular enlargement indicates mitral incompetence and is a contra-indication.

Aortic Valve Disease

Moderate degrees of both aortic incompetence and aortic stenosis may escape detection on physical examination.

In aortic incompetence the classical soft diastolic murmur is heard at the base of the heart in either the aortic, mid-sternal or pulmonary areas. The murmur is transmitted down the sternum. This murmur because of its soft quality is often missed. It can be brought out by examining the patient in a sitting position, leaning forward at the end of a deep expiration.

The murmur of aortic stenosis is harsh in quality, systolic in time, and radiates up into the neck. In both aortic incompetence and aortic stenosis the diagnosis may be made entirely on auscultatory findings.

Needless to say the detection of these murmurs is of the greatest significance as indications of organic valvular disease.

Cardiac Infarction

In the diagnosis of this very common condition we are guided by the patient's story, the W.B.C., the sedimentation rate and the electrocardiogram

much more than by the physical examination. However, it may be of interest to recount the auscultatory findings in the typical case of cardiac infarction. The apical first sound may be faint shortly after the onset. Left ventricular damage may give rise to gallop rhythm at the apex. An apical systolic murmur from dilatation of the mitral opening, with regurgitation, may occur. A precordial friction rub may be heard after two or three days in the case of a large anterior infarct. Cardiac irregularities such as premature beats or auricular fibrillation may complicate the condition. The development of basal crepitations point to cardiac failure and a less favourable prognosis.

Congenital Heart Disease

Within the past decade many refinements in the diagnosis of congenital cardiac defect have been introduced. The use of cardiac catheterization, angiographic studies and a better understanding of the radiological appearance of the congenitally deformed heart and great vessels have made for accurate diagnosis. Those of us who are not cardiologists, however, may ask "can we diagnose the presence of congenital heart disease on bedside examination?"

Auscultation has a limited value and must, of course be used in conjunction with other methods of diagnosis. Auscultation may reveal no abnormalities even with serious congenital heart disease. Murmurs may be absent. When present they are usually systolic in time and heard best at the left sternal border in the first and second interspaces. The loud machinery-like murmur of patent ductus can hardly be missed. The loud systolic murmur heard in the pulmonary area with radiation up to the neck points to congenital narrowing of the pulmonary opening. Murmurs heard over the back of the chest should make one suspicious of coarctation of the aorta.

Respiratory System

The only reference to the use of the auscultation in pulmonary tuberculosis I am going to make is to point out its limitation. All of us have learned from experience that one can miss early and indeed advanced pulmonary tuberculosis in a routine examination of the chest. It was in this condition that Laennec first described many of the auscultatory findings that we all learned as students. The stethoscope must be relegated to a poor second place to the X-ray tube in the diagnosis of pulmonary tuberculosis.

May I say a brief word as to the diagnosis of pneumonia? The physical signs which we used to learn and teach as existing in the various stages of lobar and broncho pneumonia are now seldom experienced. Two reasons may be offered in explanation. The use of sulphonamides and antibiotics has changed the natural history of pneumococcal pneumonia to the point that we no longer expect to find the classical signs of consolidation. Indeed we would be remiss if we waited for them to develop before we made a diagnosis of pneumonia and instituted treatment.

Secondly the type of pneumonia we see in 1952 is vastly different from that of twenty-five years ago. Non-bacterial pneumonias are more common. This type of pneumonia is notorious for the lack of physical signs. The stethoscope must take second place to the patient's history, the blood count and the chest X-ray.

The Gastrointestinal System

Auscultation in some cases can give valuable information and is often overlooked.

From experience one soon learns the gurgling bubbling noises that are audible in the normal abdomen from the passage of fluid and air through the intestines. In early intestinal obstruction peristalsis is increased and the bowel sounds are accentuated. If the obstruction continues the bowel musculature undergoes fatigue. Peristalsis is reduced and the sounds tend to disappear. With intestinal ileus which we now rarely see with early post-operative ambulation, auscultation of the abdomen shows few or no sounds. In generalized peritonitis we obtain similar findings the felat heart.

Central Nervous System

The physician interested in general medicine does not often think of applying auscultation as a part of the examination of the central nervous system. Occasionally, however, bruits may be heard in the head and along the vertebral column. Such bruits have been described as occurring in arterio-venous aneurysm between the internal carotid artery and the cavernous sinus. This lesion sometimes results from a fracture of the floor of the anterior fossa of the skull.

Another condition in which bruits may be heard on auscultating the head as in the arteriovenous varix.

Hemangiomas of either cranial or spinal origin are also sometimes accompanied by a murmur. Finally under exceptional conditions a meningioma of the brain may be accompanied by a murmur.

Conclusion

In conclusion, ladies and gentlemen, I feel that even with allowance for its limitations auscultation still has a place in physical examination. Even in this atomic age one would not be wise to trade in his stethoscope as a down payment on a Geiger counter.

Winnipeg General Hospital

At the Luncheon Meeting of January 15th there were two presentations. One was on Manipulative Methods and the other on Familial Periodic Paralysis which will be reported later.

I did not arrive in time to get the first part of Dr. Ryan's discourse, and in order to be sure that you get the proper information I have asked him to prepare a summary of this useful form of treatment.

As I listened to him talk my mind turned to the past. Manipulation is one of the oldest as well as one of the newest measures; one of the most heretical as well as one of the most orthodox. For is it not recorded that manipulation was not unknown to the Greeks and the Romans? And is it not true in Great Britain there are certain staunch and reputable proponents of it?

Moreover I have read that in Bohemia it was the custom to employ a crude sort of spinal manipulation for the various "doshay bolettes" that afflicted the hard-working peasants. Likewise I have read that a modification of the Bohemian Technique is, or was, employed on football fields.

As this is merely an introduction to Dr. Ryan's contribution I do not feel that I am out of order in describing the Bohemian Technique and its modification. It is not without interest although Dr. Ryan did not mention it and you may not be inclined to practice it.

In Bohemia when one was sick it was the practice for the invalid to lie prone upon the floor while some one (with his shoes off) walked up and down his or her spine. The number of excursions and degree of pressure exerted were determined by the nature and duration of the disease.

As this was a common home remedy it was practiced not infrequently by wives upon their husbands and, I imagine, less frequently by husbands upon their wives. A husband who was inclined to play sick would quickly hasten to the comparative comfort of his daily toil after his hefty spouse had strolled a few time up and down his back. This, incidentally, was the origin of chiropractic. From such base roots do glorious plants arise.

The football variant, I am informed, is practiced as follows: When a player has had the wind knocked out of him, five of his fellows rush upon him and fling him to the ground. Four of them seize one limb each and pull vigorously while the fifth, kneeling over him, punches him violently along the spine. This, writes the source of my information "quickly restores him full effectiveness."

And now, after this digression, let us pay attention to Dr. Ryan.—J. C. H.

Personal Experiences With Manipulative Therapy

G. H. Ryan, M.D.

Manipulative treatment is a subject about which the average medical practitioner knows very little. Because the method has been appropriated and exploited by irregulars, it has become the disreputable step-child of medicine and we are apt to discount its results. Experience with some forms of manipulative therapy have convinced me that in certain conditions, pain and disability can be more readily relieved by manipulation than by any other means.

1. Acute sacro-iliac strain

This is a condition frequently seen in women after childbirth, but not uncommon in men. It is characterized by pain in the lower back, not exactly midline but slightly to one side with some radiation in the upper thigh, and pain is increased by bearing weight on the affected side, either standing or sitting. Examination shows marked spasm of the lumbar muscles and usually a list away from the affected side. Movement is markedly restricted. Straight leg raising on the affected side is positive. Sometimes the posterior superior iliac spine on the affected side appears to be slightly more prominent than the other. Manipulation will relieve acute sacro-iliac strain almost instantly, whereas the conventional methods of heat, massage, recumbency on a hard bed, traction on the legs, etc., usually require two to three weeks.

2. Wry neck or locked neck

This is a condition not uncommon in young patients, sometimes seen in older. The pathology is not known but it may be due to locking of the facets, nipping of the synovia, or even direct root irritation. It may come on during sleep or occur during some motion such as turning the head. Symptoms are acute local pain in the neck, aggravated by movements of the head. The neck muscles are in spasm and the cervical spine is usually tender. Pain may radiate into the trapezii or occasionally in the subscapular region. Manipulation of the neck carefully carried out is not dangerous. While a reasonable amount of traction is made on the head, the cervical spine is put through a full range of movements. This is usually accompanied by some clicking in the joints, but this is not an essential part of the cure. Cases with degenerative changes in the discs and root irritation should not be manipulated. Anaesthesia is required for these procedures in most cases.

In Conclusion:

Having used certain manipulative procedures for the past several years without any disasters and with a great deal of satisfaction in most cases, I feel that this is a method of treatment which should be in more general use. Patients are very

grateful for quick relief of severe pain and often resentful if we fail and later a chiropractor or osteopath succeeds in providing that relief. This is happening very frequently in this city and the medical profession cannot afford to be complacent indefinitely. I believe manipulative therapy should be given a respectable place in our practice and teaching.

Case Report

An Interesting Obstetrical Complication

June 14, 1951, Mrs. T., a white woman of central European origin, presented herself at my office with history of amenorrhea. L.N.M.P. March 1, 1951, para-2, gravida-3. Physical examination confirmed diagnosis of pregnancy with an expected date, December 8th, 1951. Previous medical history was not pertinent. Progress was uneventful until September 1, 1951, when the patient was seen complaining of lower left abdominal colicy pain which on first examination was thought to be due to renal infection and was accompanied by a moderate pyuria. Treated with Aureomycin the symptoms quickly abated but recurred on September 5, 1951, character of the pain was unchanged and catheterized specimen of the urine revealed no pus. Physical examination of the abdomen revealed no indication of the origin of the pain. Patient was re-assured and on September 25, 1951, patient was seen at her home complaining of severe left-sided abdominal pain, spasmodic in character and examination of the abdomen at this time revealed tenderness throughout the entire abdomen. Fetal heart sounds were normal and bowel sounds were normal, there was tenderness on the left side of the abdomen, no elevation of temperature and no diagnosis was made. September 26, in the late evening, this patient started to vomit profusely and became rapidly dehydrated. She was admitted to hospital with a diagnosis of small bowel obstruction, nasal suction was established, intravenous fluids were given and on the following day a plain plate of the abdomen was taken and reported as follows: dilated loops of small bowel with multiple fluid levels are present in the upper abdomen, there is a gravid uterus apparently about 7 months. **Summary:** Acute small bowel obstruction. The Levine tube was removed and Miller-Abbott tube was introduced into the bowel and continuous suction was carried on until the morning of September 29, and X-ray at this time reported the tip of the Miller-Abbott tube to be in the jejunum, comparatively little small bowel gas was present now. Conclusion: evidently there is a marked improvement since the previous X-ray examination.

September 29, under spinal anaesthesia, the abdomen was opened through a large left paramedian incision. Immediate investigation of the small bowel revealed the end of the Miller-Abbott tube to be about 2 feet beyond the duodenojejunal junction and at the point where the Miller-Abbott tube had stopped an intussusception had occurred. The cause of the intussusception was a considerable amount of plastic exudate which had kinked and attached the small bowel to the fundus of the uterus. The intussusception was easily reduced and the small bowel separated from the uterus but no intrinsic disease of the small bowel was present and at this point the cause of the plastic exudate was not revealed. However, further exploration of the lower abdomen revealed a large tumor mass arising from the pelvic adnexa with a considerable amount of attachment of greater omentum to this mass. After separation of the omentum, the mass proved to be a large ovarian dermoid which had apparently undergone a relatively slow torsion and had given rise to the original attacks of pain which the patient had complained of on September 1st, and the resulting inflammatory process had produced the exudate which later led to the small bowel obstruction. The dermoid which was about the size of a large grapefruit was removed without difficulty and the abdomen was then closed. Miller-Abbott tube was left in position until October 2, at which time the patient's progress was satisfactory and uneventful until October 10, at which time the patient had several vomiting attacks. Subsequently she was discharged from hospital symptom free on October 12. The patient remained well until Nov. 27th, when she went into labor and was delivered of a 7 lb., 11 oz. male child without complication.

R. T. Robinson, M.D.

Editorial

J. C. Hossack, M.D., C.M. (Man.), Editor

Contributions from the Country

The Review is the organ of Country, as well as of City members. Rural readers learn from it much about what goes on in town. But City members learn little concerning country practice. Perhaps diffidence more than laziness is responsible for the absence of contributions from the country. But there is no reason why a practitioner's reluctance to put the facts in writing should deprive readers generally of the profit they might gain from his experiences.

Many conditions ordinarily regarded as rare or unusual are really not so infrequent in occurrence as believed. But often less-common ailments are unrecognized or, if recognized, are not reported. Again, common disorders may be associated with unusual features which make them worthy of general notice.

Recently a surgeon told me about an accident of what is probably a common sort. He said how much he had learned from this case and how he would modify his treatment in another of the same sort because of what he had learnt. I suggested that he write down his experience because several others might be faced by the same problems and encounter the same difficulties before he had an opportunity to use his newer knowledge, and these would be helped by what he had to say.

This is not the first time I have appealed to country practitioners, and I cannot feel optimistic as to the response. But the enlightenment of the profession has at no time come exclusively from cities. And no one can help the rural practitioners more than rural practitioners themselves. They know rural problems better than any urban doctor can know them. Therefore they should help each other by reporting their experiences.

Business Contributions

The fact that this is an Election Year makes it exceedingly important that every member be au fait with what is going on in our business world. All the political parties are pledged to bring a National Health Scheme into being. The extent of their generosity varies from party to party but it is our services with which they are dealing.

In the United States the violent objections and the militant attitude of the profession have done the doctors harm rather than good. Here, there has been a quiet and gradual extension of plans such as our M.M.S. and a desire to help rather than to hamper the Government. The further extension of our pre-paid plans should be encouraged. It is so easy to tell a patient that he need not have had a bill to pay if he had protected himself and his family. Under such circumstances he is likely to listen and to act.

Widespread coverage by money-saving plans which have been brought into being by the doctors themselves might make it easier to resist a state-controlled scheme. But the promise of something for nothing, even if it be but an ignis fatuus that leads astray will be as potent a lure as was Dr. Aberhart's $25.00 per month for each Albertan—a bonus for which the Albertans still wait—and vote.

The importance of this and other matters is so great that it requires special coverage. What are the various committees doing? What goes on at the meetings of the M.M.S., what is being done about fees in general and Compensation Board fees in particular? What are the problems facing the Executive? These are matters in which you have a vital interest and upon which you require information so that, at the proper time, you may be able to give proper instruction.

We have for a long time felt that it was not only desirable but imperative that these matters be brought to your attention, preferably by those most versed in them. It has therefore been arranged to add to the editorial committee a member of the Executive who, by reason of his close contact with these affairs, is in a position to gather or to write authoritative articles on questions of the moment. The choice has fallen upon Dr. Sigurdson who, from now on will furnish us with regular contributions on the business of the Association.

The Dead Line

Time waits for no man and, in publishing a journal, the Dead Line is inexorable. After it has been reached nothing can be added or subtracted. We have been having trouble with this and can afford to have such no longer.

Contributors are therefore reminded that everything must be in our hands by the first day of the month prior to publication.

This is specially important in the matter of coming meetings. Programmes, dates of meetings and the like must be given to us before the first day of the month prior to publication. Anything received later will be carried on to the following number which may be too late for the publicity required. Verbum Sap.

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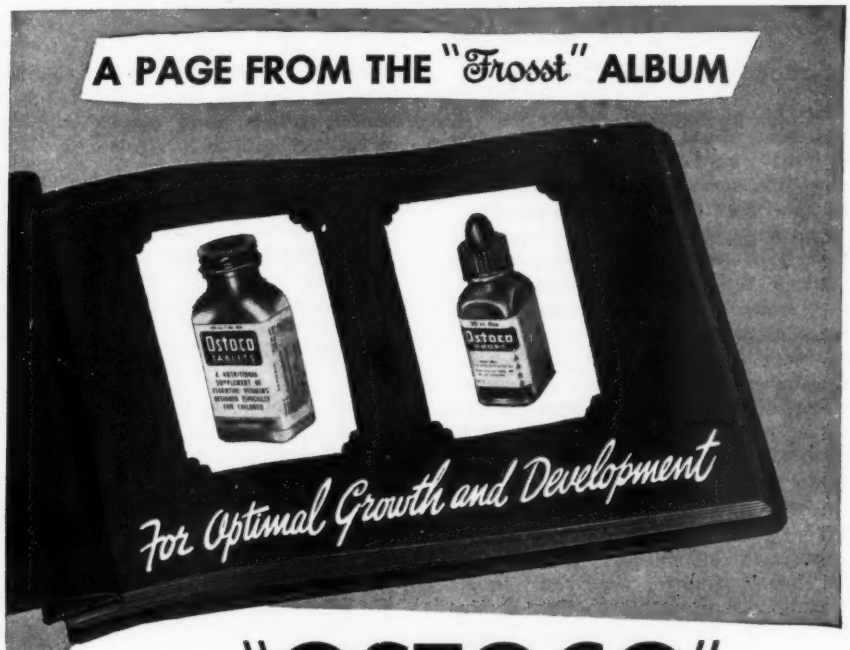

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General Practitioners

General Practitioners' Association of Manitoba
In Affiliation with the Manitoba Medical Association

Report of the President

If the ancient institution of the general practitioner of medicine is still recognized to be indispensable in the twentieth century, it should be our pride and aim to make it worthy of perpetuation. To this day the general practitioners command the largest section of medical practice. After centuries of haphazard individualism they organized themselves into fraternal groups with a paternal body recognized to represent their views and speak on their behalf on problems common to all medical practitioners and yet peculiarly their own.

More than ever before the General Practitioner has the sacred duty of maintaining the highest calibre of medical practice. For he is the genuine yardstick by which the entire profession is judged. His standard must be improved continuously with the ever growing medical research. He is in the frontline of the battle against human suffering. He must possess the ever increasing knowledge of medical science.

It is no small task to face, intelligently, a different problem with every individual who seeks his services. Otherwise he is a public hazard.

He must use his time properly in order to keep up with the scientific, economic, political and social trends and at the same time be prepared to render services whenever he is called upon.

It takes a man who visions his calling in terms of service, devotion, and sacrifice rather than prestige and recognition.

This association is yours. Whether you belong to it actively or passively, but belong to it. We are anxious that our paid membership should be increased this year. Let us make it the representative body for ALL the General Practitioners of Manitoba.

In view of the approaching Annual Meeting of the C.M.A. in Winnipeg and with full realization of our obligations to the Section of General Practice, we are anticipating an active season of the association.

May we look forward to your whole hearted support?

Sincerely yours,
V. F. Bachynski, M.D.

Report of Corresponding Secretary

The following is a brief resume of our activities during the past season:

Our past president, Dr. J. McKenty, represented the G.P.A.M. at the C.M.A. Annual Meeting in Banff last June. "Accreditation of the General Practitioners" was the chief subject of discussion. Dr. J. McKenty was chosen Vice-Chairman of the G. P. Section of the C.M.A. for the incoming year.

This year two scholarships of $150.00 each were again donated by the G.P.A.M. to the fifth year medical students (interns) interested in making General Practice their objective in life.

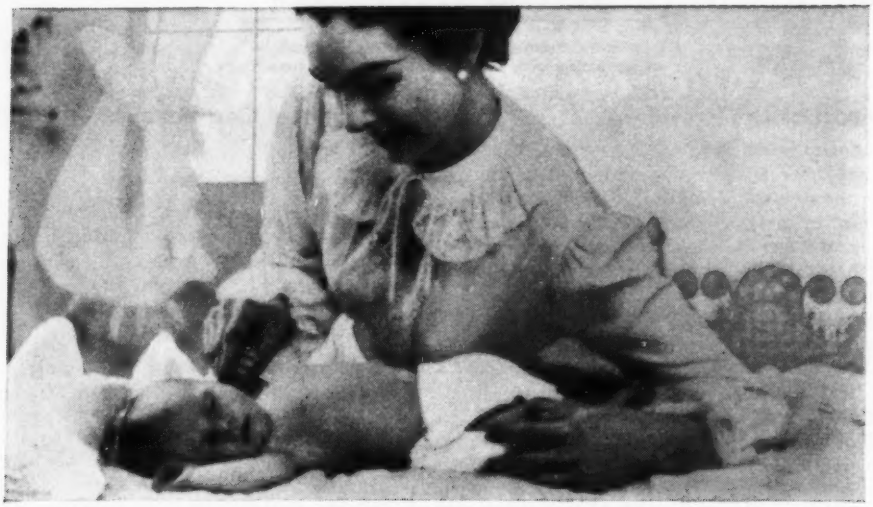
The Fee Committee made a thorough study of the Fee Tariff. The General Practitioners being a separate Block in the M.M.S., entirely separate from other groups, it was felt that G.P. fee tariff should be unrelated to others and therefore an independent schedule of fees was drawn up and submitted to the M.M.A. Fee Tribunal for ratification. This has already partially been responsible for several adjustments especially the raising of obstetrical fee.

The Annual Meeting of the M.M.A. was well attended by the members of G.P.A. A greater interest was anticipated at the Annual Dinner and Meeting. As in previous years we went into trouble and expense of inviting a guest speaker to acquaint us with the problems the practitioners are faced with in U.S. Dr. DeTar, from Milan, Mich., delivered a very timely address on this subject.

On Nov. 10, 1952, Refresher Course in Paediatrics was inaugurated. Weekly lectures will continue till March, 1953.

The G.P.A.M. is co-operating with the Faculty of Medicine Committee for Post Graduate Studies in preparation of excellent Refresher Course to begin next April. It is hoped that the rural and city practitioners will take advantage of this. Top ranking visiting speakers will appear on the programme.

Sincerely yours,
Margaret Owens, M.D.



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* Babies have high-normal hemoglobin concentration when fed meat. *Leverton and Clark, "Meat in the Diet of Young Infants," J.A.M.A., 134, 1215, (1947). Also Andelman, Gerald, Rambar, and Kagan, "Effects of Early Feeding of Strained Meat to Prematurely Born Infants," Pediatrics, 9, 485, (1952).*
* Babies allergic to milk proteins can substitute a formula made with meat. *McQuarrie and Ziegler, "Nutritive Value of Mineral-Enriched Meat and Milk," Pediatrics, 5, 210, (1950).*

Top source of protein. Swift's Meats for Babies are all meat, prepared for maximum retention of meat's nutrients: complete, high-quality protein, B vitamins, and food iron.

Easy for baby to eat. Swift's Meats for Babies can be fed by spoon at 6 weeks, or mixed with formula earlier. Strained so finely, they flow right through the nipple of a nursing bottle.

Easy to feed. The 7 different kinds tempt baby's appetite, help him learn to like a variety of meats early. When baby drinks these meats in his formula, he gets used to their flavour and texture before he reaches the "balky" stage.

Economical. Actual cost records show Swift's Meats for Babies cost only about half as much as home-prepared meats.

Consider recommending meat as one of baby's first solid foods. You will be giving your infant patients a better chance for optimal healthy growth and resistance to infectious disease. And mothers will appreciate the fact that you started nourishing meat earlier in baby's life.

Swift Canadian Co., Limited

**If you would like a reprint of any of these studies, write Swift Canadian Co., Limited, Dept. S.M.B., Toronto 9, Ontario.*

These clinical studies are part of a continuing program, originated by Swift to help provide the medical profession with specific facts on feeding meat *earlier* in the infant diet. Because of the benefits indicated by these tests, many doctors start babies on meat at 2 or 3 months. Some pediatricians recommend meat as early as 2 weeks—mixed right into the infant's formula.

7 KINDS FOR VARIETY — all 100% meat. Strained and Junior. Beef, Lamb, Veal, Pork, Liver, Heart, Liver and Bacon. AND NOW— Swift's Strained Salmon for Babies — the first and only 100% seafood for babies in Canada.

Only the finest Meats for Babies are labeled SWIFT...first with clinically tested Meats for Babies

Social News

Reported by K. Borthwick-Leslie, M.D.

As of February 1, 1953, Dr. Joseph Graf, paediatrician, announces transferring his office from the Medical Arts building to 616 Broadway Avenue. His new telephone number is 3-6118. Good luck and success in your new location, doctor, it looks very smart and modern.

♦

Attention all medical wives planning to attend the C.M.A. convention. You are asked to bring or send in your original paintings, art of any type, and ceramic "efforts." A most interesting display has been planned for the morning coffee party at Mrs. P. H. Thorlakson's. More anon about the details, but if you require more immediate information please write Mrs. Janet Deacon, 353 Cambridge Street, Winnipeg.

♦

The Manitoba Branch of the Federation of Medical Women of Canada were the guests of Dr. Marjorie Bennett, 1194 Kildonan Drive, on Feb. 5th. In spite of formidable competition of Brigadoon, Medical Arts Club Nite and convulsing infants, a goodly number of our members attended. All report a wonderful evening and say "Thank you" to the hostess. Some spade work re plans for entertaining the visiting Lady Medicos was accomplished.

♦

Speaking of Brigadoon, the management and members of the cast certainly may take a bow. An excellent performance, perfectly produced, and the Saturday matinee in aid of the Flood Relief Fund, a huge success. Everyone in tip top shape in spite of the heavy roster of the previous week.

Congratulations to Dr. Cherry Bleeks on the excellent performance of daughter Janet. Surprised at Cherry having a "vamp" in the family tho!

♦

Dr. and Mrs. R. H. McFarlane announce the birth of their daughter, Jan. 19, 1953, at the Pavilion.

The engagement of Dorothy Rose Brown to Dr. James J. Morrow, elder son of Dr. and Mrs. J. M. Morrow, Sackville Street, is announced. The wedding will take place Feb. 28, in St. Matthew's Anglican Church.

♦

It is with regret that I write of the death of one of our pioneering medical women. Dr. Isobel McTavish, head of the Clan McTavish, died in Winnipeg at 71 years, following a prolonged illness. Dr. McTavish graduated in 1915 and for 45 years served in China as a Medical Missionary. In 1920 she was honored by the Chinese Government for her faithful, fearless work. In 1940 she was interned by the Japs and spent three years in a concentration camp. Honorary pallbearers included her three medical cousins, Dr. W. J. MacTavish, Dr. J. A. MacTavish and Dr. G. B. MacTavish.

♦

Dr. Francis Mathewson, it would seem, would be well advised to start skiing, snow shoeing or straight "walking home." Two train wrecks, without injury is riding your luck, Fanny. It must have been a tough job for the two doctors.—The other was Dr. O. N. Keyes of Sussex, England, en route to Stony Plains, Alta., as medical health officer—to try to care for the many injured, especially in such bitter weather. Ghost River sounds eerie enough, without train wrecks.

♦

Everyone coming to the G.P. Valentine party at the Glendale Country Club? Better hurry, hurry, hurry, and make those reservations. The committee in charge promise a right "bang up" party. Be seeing you.

♦

Imagine that! Only one new arrival, or did I miss some. Have been trying to figure out what kept the profession so preoccupied last April and May. Could it be seasonal avitaminatosis? Curling fatigue? Or perhaps just too busy polishing up the golf club and balls—golf of course.

for dramatic relief...

at the menopause

"Premarin"

conjugated estrogenic substances (equine)

Prompt relief from menopausal symptoms is experienced by the patient on "Premarin" therapy.

A feeling of well-being and a revival of interest in normal activities are almost invariably reported.

Four potencies of tablets (one with phenobarbital) provide flexibility of potency and dosage. "Premarin" with Methyltestosterone is also available for certain selected cases. Our Medical Department will gladly send you complete information regarding dosage, further indications and clinical results achieved with the use of these orally-active estrogens.

Ayerst, McKenna & Harrison Limited
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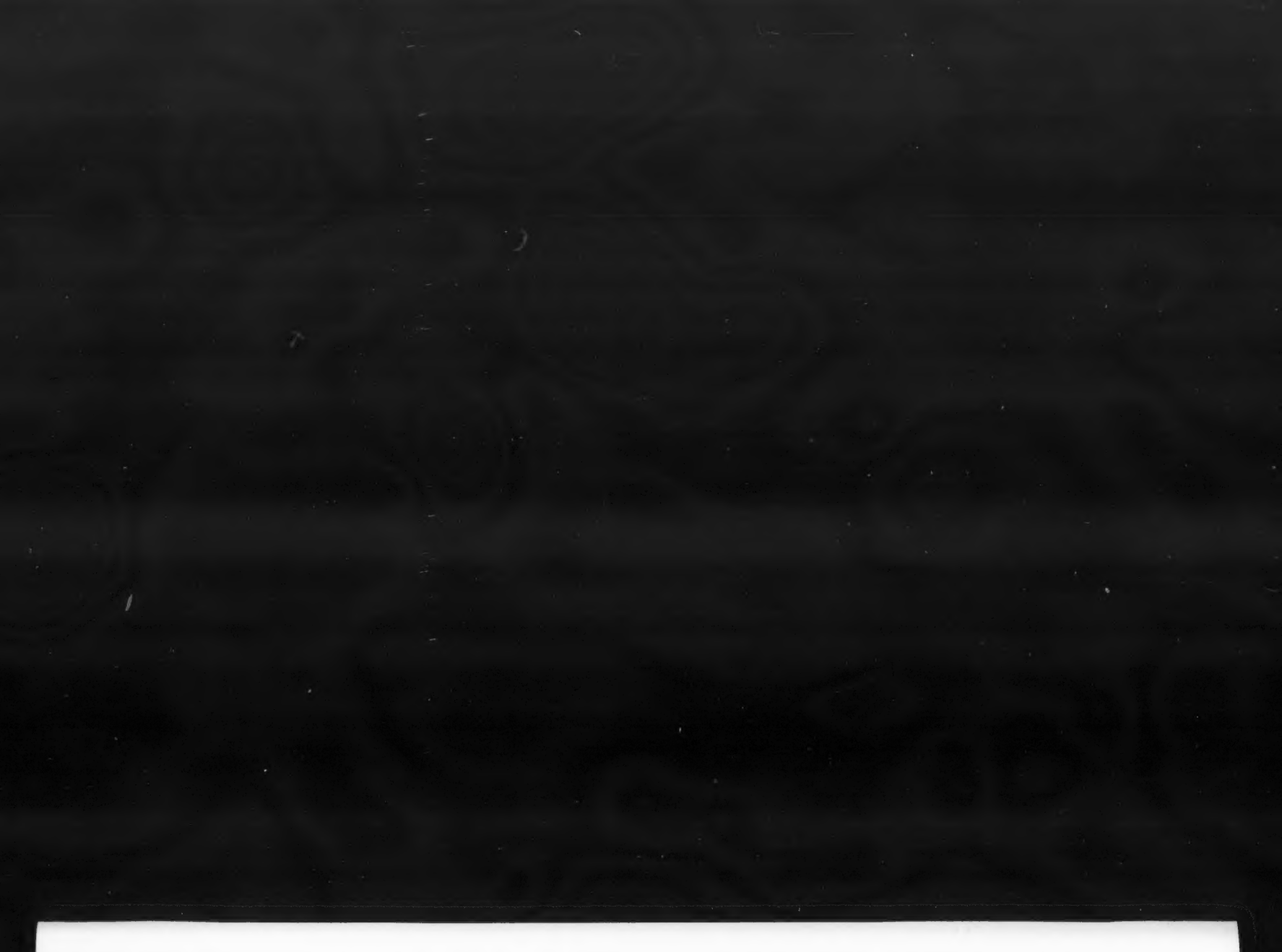


Association Page

Reported by M. T. Macfarland, M.D.

Income Tax Information

Individuals whose income—(a) is derived from carrying on a business or profession (other than farming); (b) is derived from investments; or (c) is more than 25% derived from sources other than salary or wages, are required to pay their estimated tax by quarterly instalments during such year. Each payment must be sent in with Instalment Remittance Form T.7-B Individuals. Any balance of tax is payable with interest with the T.-1 General return which is due to be filed on or before April 30 of the succeeding year.

The following timetable indicates the returns required.

A. Doctors **Not** receiving salaries amounting to ¾ of income:

Date Due	Forms to be Used
March 31	T.7-B Individuals
April 30	T.1 General
	(Note: Only doctors deriving their full professional income from salaries may use Form T.1 Short).
June 30	T.7-B Individuals
September 30	T.7-B Individuals
December 31	T.7-B Individuals

B. Doctors receiving salaries amounting to ¾ or more of income:

Date Due	Forms to be Used
April 30	T.1 General
	(Note: Doctors deriving their full professional income from salaries may use Form T.1 Short).

Whenever Status is changed* T.D.-1.

*With respect to new employer, marital status, dependents.

Doctors who pay salaries to their own employees are required to send in Form T.-4 by the end of February each year.

DOMINION INCOME TAX RETURNS BY MEMBERS OF THE MEDICAL PROFESSION

As a matter of guidance to the medical profession and to bring about a greater uniformity in the data to be furnished to the Taxation Division of the Department of National Revenue in the annual Income Tax Returns to be filed, the following matters are set out:

Income

1. There should be maintained by the doctor an accurate record of income received, both as fees from his profession and by way of investment income. The record should be clear and capable of being readily checked against the return filed. It may be maintained on cards or in books kept for the purpose.

Expenses

2. Under the heading of expenses the following accounts should be maintained and records supported by vouchers kept available for checking purposes:

(a) Medical, surgical and like supplies;

(b) Office help, nurse, maid and bookkeeper; laundry and malpractice insurance premiums. (It is to be noted that the Income Tax Act does not allow as a deduction a salary paid by a husband to a wife or vice versa. Such amount, if paid, is to be added back to the income);

(c) Telephone expenses;

(d) Assistants' fees: The names and addresses of the assistants to whom fees are paid should be furnished. This information is to be given each year on Income Tax form known as Form T.4, obtainable from your District Income Tax Office;

(e) Rentals paid: The name and address of the owner (preferably) or agent of the rental premises should be furnished (see (i));

(f) Postage and stationery;

(g) Depreciation: A description of the treatment of depreciation may be found on page four of the Income Tax Return form T.1 General under the Part XI Method.

The method of computing depreciation for tax purposes is the same as that used last year and you should have no difficulty if you have a copy of last year's return available.

Simply carry forward the balance remaining in each class after deducting last year's allowance. Add to this figure the cost of any new equipment purchased and deduct the proceeds from any disposal of property in each class. The rate you wish to use not exceeding the maximum rate (see below) is applied to this new balance for each class to obtain the depreciation you may claim this year.

The schedule on page four of the Income Tax Return is reproduced below for your information. Column (6) does not apply to doctors, the other columns are self-explanatory.

The maximum rates for the classes of equipment most used by doctors follow:

Capital Item	Class	Annual Maximum Depreciation
Medical Equipment:		
(a) Instruments Costing over $50 Each and Medical Apparatus of Every Type	8	20%
(b) Instruments Under $50 Each	12	100%
Office Furniture and Equipment	8	20%
Motor Car	10	30%

habit
time

- Habit Time of Bowel Movement—not merely relief of constipation—is secured by proper use of Petrolagar.

Petrolagar promotes development of normally hydrated, comfortable and easily passed stools.

Once achieved, the normal bowel habit may often maintain itself even though the dosage of this adjuvant is slowly tapered off.

PETROLAGAR

PETROLAGAR PLAIN, PETROLAGAR WITH PHENOLPHTHALEIN, PETROLAGAR WITH MILK OF MAGNESIA AND PETROLAGAR WITH CASCARA

Supplied in bottles of 16 fl. ozs.

Wyeth

Registered Trade Mark

Building (Residence Used Both as Dwelling and Office) 3 5%

Instruments costing less than $50.00 each belong in class 12 and have a maximum allowance rate of 100%. They should not be included in expenses but should be recorded as additions in column 3 of the schedule.

Where a doctor practises from a house which he owns and resides in, the allowance may be claimed as above on a portion of the cost of the residence, excluding land. For example if the residence were a brick building costing $12,000 and one-third of the space were used for the office, the doctor would use $4,000 as the business portion of the cost and apply the building rate of 5% to determine the maximum depreciation allowable in the first year.

For further information on the subject you may refer to the Regulations or you may consult your District Income Tax Office.

be shown that a greater allowance should be made for professional purposes.

(j) Sundry expenses (not otherwise classified) —The expenses charged to this account should be capable of analyses and supported by records.

Claims for donations paid to charitable organizations will be allowed up to 10% of the net income upon submission of receipts to your Income Tax Office. This is provided for in the Act.

The annual dues paid to governing bodies under which authority to practise is issued and membership association fees, to be recorded on the return, will be admitted as a charge. Initiation fees and the cost of attending post-graduate courses will not be allowed.

(k) Carrying charges: The charges for interest paid on money borrowed against securities pledged as collateral security may only be charged against the income from investments and not against professional income.

Schedule

(1) Class Number	(2) Undepreciated Capital Cost at Beginning of 1951 (Col. 10 of 1950 return)	(3) Cost of Additions During 1951	(4) Proceeds from Disposals During 1951	(5) Undepreciated Capital Cost before 1951 Allowsnce (Col. 2 plus 3, less 4)	(6) Net Deferred Assets	(7) Amount on which 1951 Allowance is Calculated (Col. 5 less Col. 6)	(8) Rate %	(9) Capital Cost Allowance for 1951	(10) Undepreciated Capital Cost Less Deferred Assets (Col. 7 less Col. 9)

(h) Automobile expense: (One Car). This account will include cost of license, oil, gasoline, grease, insurance, garage charges and repairs;

The capital cost allowance is restricted to the car used in professional practice and does not apply to cars for personal use.

Only that portion of the total automobile expense incurred in earning the income from the practice may be claimed as an expense and therefore the total expense must be reduced by the portion applicable to your personal use.

The mileage rate permitted in years prior to 1950 may no longer be used to estimate the automobile expenses.

(i) Proportional expenses of doctors practising from their residence:

(a) Owned by the doctor. Where a doctor practises from a house which he owns and as well resides in, a proportionate allowance of house expenses will be given for the study, laboratory, office and waiting room space, on the basis that this space bears to the total space of the residence. The charges cover taxes, light, heat, insurance, repairs, capital cost allowance, and interest on mortgage (name and address of mortgagee to be stated);

(b) Rented by the doctor. Only the rent and other expenses borne by the doctor such as heat and light will be apportioned inasmuch as the owner takes care of other expenses.

The above allowances will not exceed one-third of the total house expenses or rental unless it can

(l) Business tax will be allowed as an expense, but Dominion, Provincial or Municipal income tax will not be allowed.

Convention Expenses

"Effective January 1, 1948, the reasonable expenses incurred by members of the medical profession in attending the following Medical Conventions will be admitted for Income Tax purposes against income from professional fees:

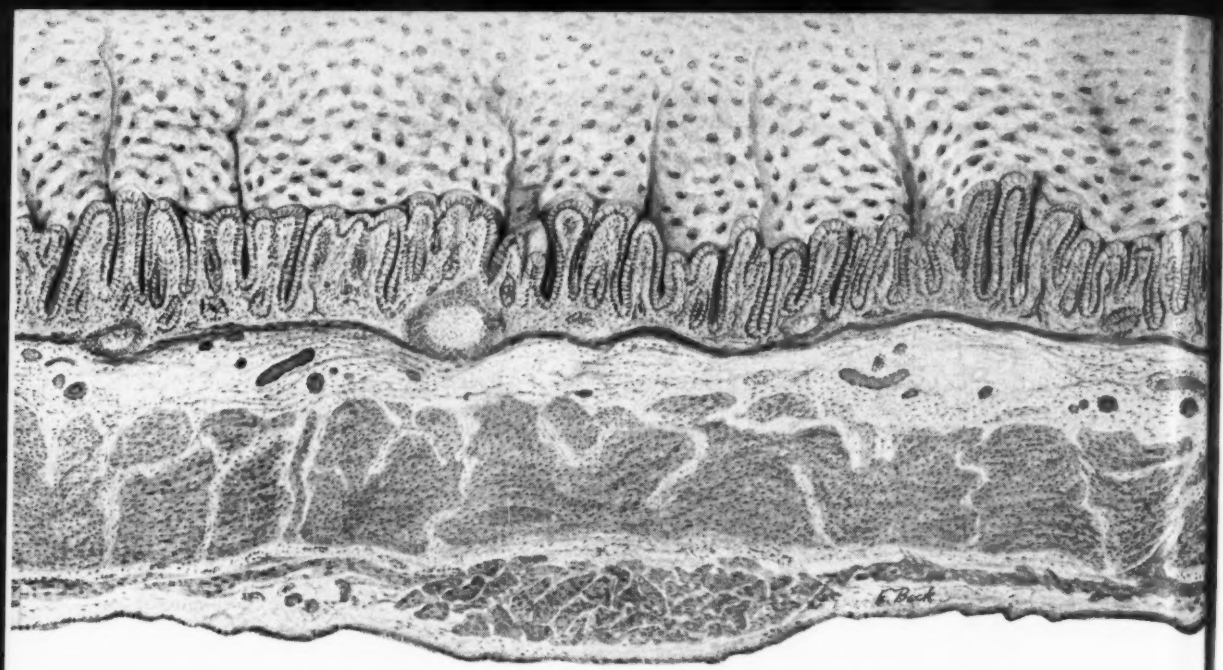
1. One Convention per year of the Canadian Medical Association.

2. One Convention per year of either a Provincial Medical Association or a Provincial Division of the Canadian Medical Association.

3. One Convention per year of a Medical Society or Association of Specialists in Canada or the United States of America.

The expenses to be allowed must be reasonable and must be properly substantiated; e.g., the taxpayer should show (1) dates of the Convention; (2) the number of days present, with proof of claim supported by a certificate of attendance issued by the organization sponsoring the meetings; (3) the expenses incurred, segregating between (a) transportation expenses, (b) meals and (c) hotel expenses, for which vouchers should be obtained and kept available for inspection.

None of the above expenses will be allowed against income received by way of salary since such deductions are expressly disallowed by statute."



Normal peristaltic action results from activity of the muscle layers as they are gently distended by bulk within the intestine; mucosal irritants cause overactivity of the muscle layers resulting in hyperperistalsis or spasm.

Corrective Action of Metamucil® in Abnormal Physiology of Constipation

Abnormally prolonged colonic retention, whether in a spastic or an atonic colon, demands the greatest care to assure correction.

The mucosa does not require stimulating; hence, stimulating cathartics, "roughage" and other physical and chemical irritating measures, are today often considered irrational.

On the other hand, the muscularis does require a stimulus to initiate peristalsis. This physiologic stimulus is the mechanism by which bland distention of the colon establishes a reflex, with the muscularis at the terminus of the reflex arc.

Metamucil literally reeducates the sluggish and also the spastic colon. Taken with adequate amounts of water, Metamucil forms a smooth, hydrophilic colloid. As this colloidal mass passes through the large intestine, it exerts a gentle, distending pressure within the lumen, thus initiating the peristaltic reflex necessary for evacuation.

A program of Metamucil therapy helps to restore proper tone to the intestinal musculature, thereby establishing proper bowel habits.

Metamucil® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

G. D. Searle & Co. of Canada, Ltd.
390 Weston Road, Toronto 9, Canada

Professional Men Under Salary Contract

The employees' annual contribution to an approved Pension Plan and alimony payments may be deducted from salary income.

Amendments to the Income Tax Act, introduced in 1951 and made retroactive to the beginning of the calendar year 1951, provide for the deduction of certain expenses from salary income.

The allowable expenses include travelling expenses, annual professional membership dues, office rent, salary to an assistant or substitute and supplies consumed directly in the performance of the duties of employment.

The annual registration fee of the Provincial medical licensing authority would be allowable if paid by the doctor himself.

Certain conditions are attached to the allowance of the expenses and without trying to recite the exact provisions of the law the main points are:

(a) That the expenses must have been incurred in the performance of the duties of the office or employment.

(b) That the employee is required, under the contract of employment, to pay the expenses.

(c) To claim travelling expenses the employee must be ordinarily required to carry on the duties of his employment away from his employer's place of business. Travelling between the doctor's home and his office is not included.

Where the travelling expenses are allowable under these provisions, depreciation may be claimed on the automobile used for this purpose but no other claim for depreciation may be made.

Income From a Partnership

Additional expenses incurred by a partner, but not charged to the partnership, may be claimed as a deduction from the partner's share of income. However, the partner must be in a position to substantiate these expenses, to show why they were not charged directly to the partnership and that they were necessarily laid out to earn the partnership income.

Schedule of Minimum Fees, Manitoba Medical Association, 1946

The orange-covered Schedule has become outdated. Some alterations have been made and new procedures have been added, but the necessity for complete revision has been recognized for some time.

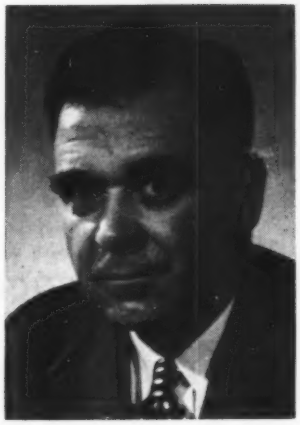
The Fee Committee has undertaken the revision, and has invited the active co-operation of Members, Groups, Sections and District Medical Societies in completing the forms which have been mailed to each member.

Each procedure carries only one proposed Minimum Fee. Members, Groups, Sections or District Medical Societies are invited to study the prepared list and to submit, in writing, the Minimum Fee which they consider each procedure warrants.

It has also been proposed that the revised Schedule contain only the Minimum Fee applicable to each procedure, thus avoiding duplication which existed in the previous Schedule.

Only signed statements will be considered, and returns should reach the office of the Executive Secretary, 604 Medical Arts Building, on or before March 1st, 1953.

Post Graduate Studies



John Ferguson McCreary, M.D.

Dr. McCreary, who is the Professor and Head of the Department of Paediatrics, Faculty of Medicine, University of British Columbia, will be one of the guest speakers at the Refresher Course to be held in Winnipeg, April 13-17, 1953.

He is a graduate of the University of Toronto, where he was on the staff of the Hospital for Sick Children from 1936-39. In 1940 he was at the Harvard Medical School and the Boston Children's Hospital, returning to the Hospital for Sick Children in 1945 where he remained until 1951. During this time he was also consultant to the Grace Hospital in Toronto.

Dr. McCreary is a member of the Canadian Society for the Prevention of Diseases in Childhood, the Paediatric Research Society and the American Academy of Pediatrics.

During the war Dr. McCreary served with the R.C.A.F. from 1942-45 as a Consultant in Nutrition. In 1944 he was detached to S.H.A.E.F. headquarters for examination of children of Europe and held the rank of W/C.

Subjects to be discussed by Dr. McCreary will be published in the next issue of the Review.

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for symptomatic relief

in the common cold

CORICIDIN produces quick suppression of cold symptoms because it contains chlorprophenpyridamine maleate, the most potent antihistamine available. Best results are obtained when CORICIDIN is taken early, but even in later stages considerable comfort is afforded.

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Each CORICIDIN Tablet contains 2 mg. chlorprophenpyridamine maleate and the standarrd APC combination.

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Manitoba Medical Service

*Financing the Cost of Our New Premises

Dr. P. H. McNulty
Chairman of the Board of Trustees

Mr. President, Ladies and Gentlemen:

It is a privilege to be with you this evening for the discussion of a project which concerns us all. Some of you may recall that several aspects of the project were described by Dr. Corrigan, the Treasurer of M.M.S., and myself during recent sessions of the Manitoba Medical Association Convention. However, as so much interest has been aroused by the M.M.S. venture into the field of building, and as so many enquiries have been addressed to us, it has been deemed expedient by Dr. Childe, your worthy President and an exemplary member of the Board of Trustees of M.M.S., to devote some time this evening to a consideration of our activities.

At this point I would submit two paradoxical propositions:

1. For the cost of construction of the building there is not one cent coming from the subscriber.
2. For the cost of construction of the building there is not one cent coming from the participating physician.

As we develop the subject, you shall see why.

Also at this point, let me enumerate some of the questions asked of us as we move about in medical circles:

1. Why should recent medical members derive benefits from funds supplied by the senior participating physicians?
2. Why not use surpluses to increase prorating assessment?
3. Why do we have to build?
4. Why plan such an expensive building?
5. Why build over Colony Creek?
6. Why choose such an expensive site?

For a moment, we do well to remind ourselves of the inception of the M.M.S. To obtain credit from banks, we received promissory notes from many of our colleagues and substantial loans from your Society (Winnipeg Medical Society), and from the M.M.A. and C.P. & S. These M.M.S. obligations were discharged promptly.

Now let us turn to three of the many Tables prepared from our M.M.S. records and consider them in turn as A, B, C.

Over a period of years it has been necessary to have a fund to stabilize monthly payment of medical claims especially in periods of emergency or in situations of sudden change. It is computed and generally accepted that a fund equal to two months of claims payable is necessary for such a fund, or "reserve" as it is sometimes called. It was not possible to amass any amount up to 1945 but from 1946 to the end of October, 1952, there has grown up a sum now reaching $271,160.32. This figure represents money which could have been distributed to members and you may see from Table A that the most of this money accrued during the year 1951. Please make a note of that for it answers Question 1. This fund is then a stabilizing device, through which we are able to predetermine a pro rata figure for medical-claims payment in months of predictable income but unpredictable claims filed against M.M.S. We shall not elaborate on the advantage of such an arrangement.

TABLE A

Year	Membership	Income	Detained for Contingency
45	25115	227100.61	L 4557.36
46	35789	366361.62	4302.61
47	39292	507191.78	37827.88
48	51336	629503.06	76145.25
49	62161	770959.22	89882.97
50	87082	1038430.42	91741.60
51	118210	1866667.94	221008.76
52*	137275	2184481.69	271160.32

*Including October 31, 1952.

Now we shall digress a little to remind you that premiums are prepaid by subscribers and deposited in the M.M.S. Savings Account. For services rendered during the month of coverage (X), the claim is lodged by the 10th day of the month following (Y) and on the 15th day of the next month (Z), the physician is paid. Thus we have the custody of the subscribers' premiums for two months, and for part of a month, this custody amounts to three months' premiums. A substantial minimal monthly balance is thus established, and on this sum in Savings Account we have made bank arrangements to receive ½ of 1% per annum as interest.

Let us look now at Table B which represents the situation at 31st October, 1952. Notice, for August, 1952, that processed claims amounted to $183,062.70 and these fees were remitted to doctors on 15th October, 1952. For September, 1952, processed claims amounted to $205,336.86 to be paid to you on 15th November, 1952. On the claims

TABLE B
P. & S. CLAIMS CASH AMOUNT

Month of Service	Claim Amount	Date of Payment	Funds available at Oct. 31
Aug.	183062.70	Oct. 15	
Sept.	205336.86	Nov. 15	
Oct.	238672.00*	Dec. 15	
			444,008.86

*Amount as rendered but not assessed.

*Delivered before the Winnipeg Medical Society on 21st November, 1952.

rendered for October, 1952, (as received by M.M.S. by 10th November, 1952), a pro rata payment of 80% amounts to $238,672.00 and this will go out to members on 15th December, 1952. From all this it is clear that a sum exists amounting to $444,-008.86 in a Savings Account; and a similar cycle is caused all the year round from two factors: (1) advanced payment of premiums by subscribers, (2) the time lag in assessing claims for services rendered to subscribers or dependents. This, in other words, is not "cash and carry" but "carry and cash." Please note carefully that this fund of over 400,000 dollars is the money available to cover the costs of construction. It is almost incredible, you may say. Nevertheless, the facts have been studied and restudied from every angle and this method of financing has been endorsed—not only by the Trustees of the M.M.S. but also by the Executive Committee of the Manitoba Medical Association and by the general membership of the M.M.A. in the business sessions of the Annual Meeting, October, 1952. So we shall convert your liquid assets (bank account) into fixed assets (a building), and, while the former will bring in ½ of 1% in interest, I think I can show you a comparable amount from your fixed asset. On this matter of conversion of M.M.S. liquid assets, I should add that the M.M.S. Directors have acted on sound legal advice and have satisfied legal counsel that the subscribers' interests will not be jeopardized.

All this may be an answer to Question 2.

Now, with a view to reconverting the asset from fixed to liquid state, it is proposed to amortize the building over a period of 40 years, to replace the moneys in the Savings Account and to pay appropriate interest and in the end to have a building free from debt.

Let us look now at Table C. Let us assume for the sake of discussion that the cost of the project is $400,000. This amount amortized over

TABLE C

New Arrangement (Building) 15000 sq. feet		Present Arrangement (Lease) 10000 sq. feet	
Int. & Prin. ½%	11058.	Rental	15000.
Taxes	10000.		
Heating	1000.		
Caretaker, water & supplies	5000.		* 2495.60
	27058.		17495.60

*Actual figure.

Cost to M.M.S. on Rental Basis
By proposed new arrangement (building)=
1.80 + per sq. ft. per year.
By present arrangement (lease)=
1.75 + per sq. ft. per year.

a period of 40 years with interest at the rate of ½ of 1% gives a yearly payment of $11,058. To this is added about $10,000 for taxes, for heating a sum of $1,000, and for caretaking and supplies a figure of $5,000, giving a total of $27,508 per year for some 15,000 square feet of usable space. That represents a rate of $1.80 per square foot per year for new premises on Osborne Street. For the space we now occupy in a warehouse with unsanitary conditions, fire hazards and absence of standard facilities, M.M.S. is paying $1.50 per square foot per year plus 25 cents per square foot per year for caretaker services and supplies, for a total of $1.75 per square foot per year. Thus the difference between the present and future is 5 cents per square foot per year. In passing, let me remark that our rental up to and including 1951 was $5,000; in 1952 double this space was required and the rental jumped to $15,000 excluding caretaker service and supplies. Still more space is required and there is no foreseeable stabilization of rentals. What do we get under our own project for $1.80 per square foot per year? To mention but a few, there are: (1) adequate and appropriate space and facilities for present needs and potential expansion; (2) suitable layout of offices for smoother work flows; (3) sanitation up to standard requirements; (4) fireproof storage space for our records; (5) elevation of morale of employees; (6) security of tenure of space; (7) enhanced prestige, position and promotional power for the profession in dealing with the public or with government, local or provincial.

I submit that these accrued advantages are well worth $1.80 per square foot per year and may answer Questions 3 and 4.

We have heard the bogey of Colony Creek and our choice of site has been criticized. Now, you need have no fear of flood damage for there is no basement in our building and the reinforced concrete piers extend down to hardpan well below the level of the creek. It is, I think, the first three or four-storey building to be so constructed in Winnipeg and I will assert that the city streets will be covered with one foot of water before the scrap paper in our waste basket is dampened. Question 5 is I believe answered.

As for Question 6, "Why choose such an expensive site?" I am embarrassed if you ask me the purchase price of the ground; but the truth must be told—it was $11,000 and within a month of purchase it could have changed hands for twice that sum. The site is on a most desirable location in Winnipeg and while it may be about $300 more per year for land taxes than on a site in, let us say, Point Douglas, we should still have to pay the same building taxes had we chosen the latter site. So it comes to this: for a preferred site in the hub of the wheel of Greater Winnipeg with all the advantages, tangible and otherwise, we shall be paying something less than a dollar per day. I submit that this is a reasonable price to pay.

We have by now covered rather quickly the main features of M.M.S. financing and dealt with

some of the criticisms of the perturbed few. As we have to go on with the project, let me ask you for the "tools to finish the job"—not hammer and nails, not shovels and sands—all these we can get from the contractor; from you as partners in this venture we ask firstly, co-operation; (2) criticism ever founded on fact; (3) more knowledge of the M.M.S. as regards policy and administration; (4) sharing this knowledge with your less informed colleagues, particularly newer and younger members; (5) use of your professional relationship with patients to emphasize the basic concepts of prepaid medical care; (6) optimism in the potentialities of the Manitoba Medical Service.

May I remind you that the Board consists of medical and public representatives drawn from many sectors of the business, commercial and professional life of the Province. These non-medical members have always recognized the right of our medical representatives to the leading executive offices. Thus we have the Hon. Treasurer and Secretary as vigilance officers on administrative costs and let me add that our administrative expenses are the lowest of any medical care plan. As Chairman of the Committee on New Premises we have our admirable Dr. Bleeks who has served as Chairman of the Board of Trustees and continues to give a magnificent service as head of this important committee. As Executive Director we have Dr. MacMaster, and it is not fully realized how fortunate we are to have him as our chief. To his flair for administration, he adds a background of medical experience and practice plus a philosophy that understands and appreciates medical problems. These attributes can not be found in the same measure in a non-medical Executive Director and we in M.M.S. lay great stress on the possession of these qualities by anyone heading a plan dealing with doctors. This is in line with C.M.A. thinking and represents a point of view which I hold in dealing with affairs of the Trans-Canada Medical Services.

Our public representatives have done us the honour of according the leading positions to physicians. Our non-medical members are partners with us in a challenging community enterprise. They look to us for leadership. However, be assured, ladies and gentlemen that these public representatives are not, and never will be, the rubber stamps for the medical profession. They have elevated me to a position of honour with great responsibilities and given me every possible support and guidance. If our building project fails, the responsibility will lie heavily on me, and on me alone.

In closing, Ladies and Gentlemen, let me re-emphasize that in the M.M.S. you have an organization second to none on the North American Continent and one that is the envy of foremost students in the welfare field. By their thinking, you have the answer to socialized or state medicine or variants of the same. Would that some of the other provinces assimilated your principles and shaped plans on your policies. This would do much to arrest the pressure from the public or maybe it is from the politicians, for alternative schemes of medical care.

So long as we faithfully observe our obligations and duties to our public in this grand community enterprise—the M.M.S.—we need have no fear of any threat to our traditional rights and privileges; we shall retain our freedoms.

Clinical Luncheons

Clinical Luncheons are held at 12.30 p.m. at the various Winnipeg hospitals shown:

Deer Lodge	First Monday
General	First Thursday
Children's	First Friday
Misericordia	Second Tuesday
St. Boniface	Second Thursday
Victoria	Second Friday
Grace	Third Tuesday
General	Third Thursday
St. Joseph's	Fourth Tuesday
St. Boniface	Fourth Thursday
Municipal	Fourth Friday

The Winnipeg Medical Society usually meets at 8.30 p.m. on the third Friday of each month.

Factual information for physicians about *Ramses* Vaginal Jelly . . .

Wide clinical use has proved the dependability of RAMSES* Vaginal Jelly. There are three excellent reasons why this is so:

First.. Tests conducted by an independent accredited laboratory establish that no product exceeds its *immobilizing speed,* when the officially recognized test is employed.

Second.. RAMSES Vaginal Jelly provides effective *barrier action.* Julius Schmid was the *first* to use the synthetic gum, sodium carboxymethylcellulose, as a base for a vaginal jelly. This gum has been shown, by direct color photography, to have adherence properties which provide complete occlusion for at least 10 hours after application to the cervix.

Third.. *All* RAMSES Gynecological Products, as a matter of policy, are offered for use *only* under the guidance of the physician.

*The word RAMSES is a registered trademark.

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Book Review

Office Psychiatry, by L. G. Moench, is described as "a concise, down-to-earth manual" on the Management of the Emotionally and Mentally Disturbed Patient (young and old, male and female); and in his Preface the author writes: "This book is not designed to make a psychiatrist of every medical practitioner, nor to be an atlas of rare and esoteric psychiatric syndromes. It is presented to the general practitioner, the non-psychiatric specialist and the medical student in the hope that it will increase their understanding of the patient as a person, thereby extending the range of their usefulness to the patient and adding to their own satisfaction."

The book lives up to these statements. The language is clear and simple. The reader is not expected to be familiar with ponderous scientific phraseology and so that is avoided. The illustrations are amusing and their simplicity increases their value.

Prenatal influences are first discussed. The popular superstitions are discounted, but it is stressed that the attitude of the mother towards her pregnancy, by colouring her gestational behaviour, and her subsequent attitude towards the child, may be very potent influences.

Upon the emotional health of the child depends the emotional and even the physical health of the adult. The author devotes a good deal of space to this matter. He explains how the personality is developed, what things favour a healthy development and how damage, often irremediable, can be unwittingly inflicted.

The problems of adolescence are particularly perplexing for both parents and physicians, and to the adolescents themselves. It is the time when the child begins to feel within him the stirrings of the adult. He is about to become independent and his efforts towards emancipation become both an outward and an inward struggle.

The reactions of youth are natural enough; but if uncontrolled or undirected, they may lead to trouble both in the present and in the future. Moench explains the reasons for the underlying drives, the reasons for specific reactions and the handling of the youth who finds this age a time of trouble.

Regarding psychosomatic medicine it is pointed out that nothing is new about this but the name. It is the oldest form of good medicine. But what used to be loose and scarcely understood is now gathered together and made understandable. As is now common knowledge the somatic disorders of psychic origin are almost legion. How are these distressing symptoms brought into being? Why should in one case the heart, in another the lungs, in a third the skin be the specific area chosen for the display of symptoms? These are some of the questions for which answers are sought. To understand their pathogenesis one is forced to study the patient who so complains. The chapter on Psychosomatic Medicine is a guide to the understanding of the patient.

The neuroses are the most prevalent of all ailments. In major or minor degree they afflict the majority of people in these hectic days. The bases, mechanisms and manifestations of this malady are all discussed and both prevention and treatment are considered. What we read here about anxiety neurosis, about hysteria and neurasthenia and obsessive-compulsive disorders, phobias and the like are discussions about states which need never have arisen.

The major psychoses are of a somewhat different sort. In some the soil is so fertile of mental reactions that scarcely any seeding is necessary for lusty growth. In others the absence of necessary chemicals or the introduction into the body of harmful ones upsets the balance. Psychopathy, schizophrenia, depressions, addictions, the effects of old age—all these entities are discussed from the standpoint of cause, recognition and treatment.

So far we have been instructed in the manifestations of various emotional and mental disorders, and have been shown the mechanism which lies behind them. But two important matters still remain. First, how is one to gather the necessary data; and, second, what can be done to help the patient?

There is a chapter on "The Psychiatric Examination" and one entitled "The Interview." These give general instructions on the procedures to be followed in gathering the facts. Not only is advice given as to what to do but also what not to do, which may be equally important.

The section on treatment opens with a chapter on "Psychotherapy in General Practice and Non-Psychiatric Specialties"; and this is followed by others on psychoanalysis, insulin, electric shock and psychosurgery. A knowledge of the latter three techniques is desirable, even if the reader is not likely to apply them, because they indicate when these procedures are of value and what the patient is likely to undergo.

The book is a very useful one. It is easy to read, is clear in its instruction and those who have it will find it of almost daily usefulness.

Office Psychiatry: The Management of the Emotionally and Mentally Disturbed Patient by Louis G. Moench, M.D. Assistant Clinical Professor of Medicine and Psychiatry, U. of Utah Medical School. 310 pages with illustrations. Year Book Publishers Incorp. Published in Canada by Burns & MacEachern, Toronto. Price $6.50.

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College of Physicians and Surgeons of Manitoba

Council Meeting

Ocober 11th, 1952.

The Sixty-seventh Annual Meeting of the Council of the College of Physicians and Surgeons of Manitoba was held Saturday, October 11th, 1952, at 10 o'clock a.m., at the Medical College, Winnipeg.

The President, Dr. F. K. Purdie, called the meeting to order.

1. Roll Call

The following members were present: Doctors F. K. Purdie, President; C. E. Corrigan, Vice-President; T. H. Williams, Treasurer; M. T. Macfarland, Registrar; A. R. Birt, W. J. Boyd, B. Dyma, A. P. Guttman, G. H. Hamlin, Ed. Johnson, Wm. Malyska, A. L. Paine, T. W. Shaw, F. H. Smith, C. B. Stewart, S. S. Toni, C. H. A. Walton and Wm. Watt.

The president welcomed the following new members to the Council: Dr. A. B. Birt, University of Manitoba; Dr. A. P. Guttman, North Winnipeg; Dr. G. H. Hamlin, Portage la Prairie; Dr. F. H. Smith, P.S. & S.; Dr. S. S. Toni, Lisgar.

The president presented the following list of names of members of the college deceased during the year:

Doctors George Perry Armstrong, Portage la Prairie, Man. Percy George Bell, Victoria, B.C. Edgar Alexander Campbell, Winnipeg, Man. Thomas Hughes Cuddy, Winnipeg, Man. Oswald John Day, Winnipeg, Man. Joseph Oliver Genereux, Webster, Mass. Walter Henry Gabriel Gibbs, Selkirk, Man. Clifford Rogers Gilmour, Winnipeg, Man. Howard Harvey, Winnipeg, Man. Hans Herschman, Winnipeg, Man. William Alexander Howden, Neepawa, Man. Richard Wellington Kenny, Winnipeg, Man. Robert Kippen, Newdale, Man. Oscar Margolese, Winnipeg, Man. Henry Oliver McDiarmid, Brandon, Man. John Bruce McGregor, Saskatoon, Sask. John Elgin Moran, Lashburn, Sask. Gerald Michael Olin, Winnipeg, Man. Baldur Haroldson Olson Winnipeg, Man. Richard Oscar Tobias Rice, Warburg, Alta. Francis Sedziak, Ottawa, Ont. Austin Bryce Simes, Fort Qu'Appelle, Sask. John Smith Stewart, Winnipeg, Man. Robert Rennie Swan, Winnipeg, Man. May Fanny Whittaker, Toronto, Ont. David R. Williams, Winnipeg, Man. Graham Wilson, Winnipeg, Man. Alexander Robert Winram, Winnipeg.

Results of Election

Report of Returning Officer and Scrutineers:

The Registrar presented the following report.

As Returning Officer of the 1952 elections, I beg to report that the following members were appointed to the Council by acclamation:

Selkirk ..... Dr. Ed. Johnson, Selkirk
Souris ..... Dr. Wm. Malyska, Deloraine

The results of the election in the remaining districts are as follows:

Brandon ..... Dr. F. K. Purdie, Griswold
Dauphin and Nelson ..... Dr. P. Johnson, Flin Flon
Lisgar ..... Dr. S. S. Toni, Altona
Macdonald ..... Dr. A. L. Paine, Ninette
Marquette ..... Dr. T. W. Shaw, Russell
Neepawa ..... Dr. Wm. Watt, Neepawa
Portage la Prairie ..... Dr. G. H. Hamlin, Portage la Prairie
Provencher, Springfield and St. Boniface ..... Dr. F. H. Smith, St. Boniface Centre
Winnipeg North ..... Dr. W. J. Boyd, Dr. T. H. Williams
Winnipeg South ..... Dr. B. Dyma, Dr. A. P. Guttman
Winnipeg ..... Dr. C. E. Corrigan, Dr. C. B. Stewart

I herein certify that this is a correct report of the details furnished by the scrutineers.

Respectfully submitted,
M. T. Macfarland, M.D., C.M.,
Returning Officer.

Drs. E. F. E. Black and A. R. Birt, Scrutineers.
October 1, 1952.

The Registrar presented a communication from the Secretary, Medical Faculty, University of Manitoba, advising that Drs. A. R. Birt and C. H. A. Walton were elected to represent the Faculty on the Council for a three-year period to coincide with the tenure of office of other elected members of Council.

Election Statistics

The following statistics were prepared in reference to the 1952 elections:

Electoral Districts	Number of Physicians	Number Eligible	Number Nomination Papers Returned	Number Nominated	Number Nominations Accepted	Number Voting Papers Returned	Spoiled Ballots
Brandon	48	45	18	4	4	33	1
Dauphin and Nelson	43	43	13	7	4	26	—
Lisgar	15	14	5	2	2	7	—
Macdonald	20	20	7	4	4	13	1
Marquette	21	21	6	4	4	13	—
Neepawa	19	18	7	4	3	11	—
Portage la Prairie	19	19	6	4	3	14	—
Provencher, Springfield and St. Boniface	75	72	21	9	7	36	—
Selkirk	34	32	5	1	1	Accl.	—
Souris	14	13	7	1	1	Accl.	—
Centre Winnipeg	60	57	14	11	9	32	—
North Winnipeg	45	41	9	6	4	27	—
South Winnipeg	396	374	52	27	20	168	6
Totals	809	769	170	114	66	380	8

Motion: "THAT the report of the Returning Officer and Scrutineers be accepted and that the Nomination and Voting Papers of the 1952 election of the Council of the College of Physicians and Surgeons of Manitoba be destroyed." Carried.

Payment of Scrutineers

Motion: "THAT the Scrutineers for the 1952 elections be paid the fee of Twelve Dollars and Fifty Cents ($12.50) each for their services." Carried.

2. Reading of Minutes and Their Approval

The Registrar stated that the minutes of the May Council meeting had been mimeographed and circulated to the members of Council.

Motion: "THAT the minutes of the May Council meeting be taken as read." Carried.

3. Reports of Officers and Their Consideration

A. Registrar's Report

Before submitting his report the Registrar outlined the highlights of business transacted by Council since 1945 for the information of new Council members.

Mr. Chairman and Members of Council, it affords me a great deal of pleasure to present herewith the fifth annual report since a joint committee of this College and the Manitoba Medical Association agreed to the fusion of offices of Registrar and Executive Secretary.

I wish to acknowledge with gratitude the excellent co-operation which I have secured from all members at all times. I realize that the calls are often at inconvenient times for busy practitioners, but the response has always been prompt.

Meetings

During the year there have been:

1 special meeting of Council on May 17th, 1952.

3 meetings of the Executive Committee, 2 prior to and 1 subsequent to the May meeting of Council.

8 meetings of the Registration Committee, 5 prior to and 3 subsequent to the May meeting of Council.

2 meetings of the Finance Committee, both prior to the May meeting of Council.

2 meetings of the Specialist Committee, 1 prior to and 1 subsequent to the May meeting of Council.

The majority of meetings have been held at noon, evenings or Saturdays.

Mimeographed copies of all meetings have been circulated to members. Not all have been printed in the Manitoba Medical Review.

Certificates

Of 73 applications for Student Registration all were granted. This is higher than 70.6 average for the past five years. Several applications have not yet been received from this year's class.

Of 127 applications for Enabling Certificates 111 were granted. This is higher than the 5-year average of 78.8. 16 were deferred pending receipt of additional information.

Of 26 applications for Certificates of Licence (temporary) 26 were granted. This is also higher than the 5-year average of 20. 4 were issued without payment of a fee as they were registered and in good standing in another Canadian province, and members of Her Majesty's Permanent Forces. Of these 21 remain in effect.

The schools from which the applicants graduated were as follows: Manitoba, 14; other Canadian, 5; United Kingdom, 7. 5 Temporary Licences were cancelled, and 2 were replaced by Permanent Registration Certificates. It is interesting to note that of the 101 Certificates of Licence issued since the inception in 1947, only 25 remain in effect at the end of the college year.

Of 85 applications for Certificates of Registration, for which all supporting documents were presented, 84 were granted, and 1 was deferred pending receipt of additional information. 7 were replacing Temporary Licences.

The schools from which the applicants graduated were as follows: Manitoba, 43; other Canadian, 3; U.S.A., 2; United Kingdom, 17; European, 11; Asia, 7; Australia, 1.

Registered doctors in Manitoba, Sept. 30, 1952:

	Perm.	Temp.	Total
Greater Winnipeg	557	16	573
Outside Winnipeg	242	9	251
	799	25	824

There has been a steady increase since 1944, but this is the largest number of doctors ever registered and resident in this Province.

Changes in the Register

During the year October 1, 1951, to September 30, 1952, in addition to those who were fully or temporarily registered, 27 members were removed by death; Winnipeg 15, Rural Manitoba 5, outside Manitoba 7. 70 members left the Province, while 17 previously registered returned to the Province. There were 126 changes of address within the Province, and 21 changes of address outside the Province.

A spot check carried out independently from the individual cards, and NOT reconciled with the official count recorded above, gave the following age and occupational status of physicians practising in the Province at September 30th, 1952.

Age	Winnipeg	Outside Winnipeg	Total
25	7	0	7
25 - 34	138	110	248
35 - 44	168	51	219
45 - 54	112	38	150
55 - 64	85	28	113
65 - 74	41	19	60
75 - 84	34	11	45

85	1	2	3
	586	259	845

(Figures taken on five successive days—probably some duplication).

Occupation	Winnipeg	Outside Winnipeg	Total
Active Practice	383	194	577
Administration	39	10	49
Institutional	96	25	121
Armed Services	6	8	14
Non Practising	32	11	43
Retired	30	12	42
	586	260	846

(Figures taken on five successive days—probably some duplication).

Members Granted Life Memberships

October 1, 1951—September 30, 1952:

Breidenbach, Lambert ..... Altona
Brownlee, Thomas, Irwin ..... Russell
Cameron, Archie Peter ..... Swan River
Fahrni, Gordon Samuel ..... Vancouver, B.C.
Martin, John Roy ..... Winnipeg
Onhauser, Vincent Frank ..... Winnipeg
Pearlman, Isaac ..... Winnipeg
Shier, Laurence Roy ..... Pierson
Warner, Norman Wilfred ..... Winnipeg

Cash Receipts

Annual Fees			$3,879.00
Registrations	68 x $100	$6,800.00	
	5 x 90	450.00	
	9 x 80	720.00	
	Balance—Dr. Lavoie	5.00	
			$7,975.00
Temporary Licences	21 x 10	210.00	
	2 x 5	10.00	
			220.00
M.C.C. Certificates	87 x 5	435.00	
	24 x 25	600.00	
			1,035.00
G.M.C. Certificates	10 x 5		50.00
Student Registration	73 x 1		73.00
Specialist Registration	43 x 5		215.00
Miscellaneous			
Lists of changes	17 x 1	$ 17.00	
	36 x 2	72.00	
Lists of doctors	27 x 3	81.00	
	52 x 5	260.00	
Documentation Fees	20 x 25	500.00	
Postage (Drs. Wang and Tsai)		2.00	
U.S. Premiums		6.38	
			938.38
			$14,385.38

Arrears of Annual Fees—1950, 1; 1951, 1; 1952, 10.

It is my opinion that Council must decide whether the outlook will be distinctly provincial or federal and international. If the former, it will be necessary to confine ourselves to the strict wording of the Medical Act and provide Enabling Certificates only to those who reside and interne in the Province, and whose stated intention is to practise medicine in Manitoba. In the latter case it will be necessary to maintain adequate secretarial assistance and/or provide a full-time Registrar.

Respectfully submitted,
M. T. Macfarland, M.D., C.M.
Registrar.

Motion: "THAT the Registrar's report be adopted." Carried.

B. Treasurer's and Auditors' Reports

Your Treasurer begs to submit the following report for the year 1951-52. Herewith also submitted the Auditors' Report.

Gordon Bell Memorial Trust Fund

There have been no bond changes in this account, and there are $25,500.00 in 3% Dominion of Canada bonds in our strong box at the bank.

Interest earnings in this account during the year total $775.02.

As authorized by Council and at the request of the Gordon Bell Memorial Committee a scholarship allowance of $150.00 per month has been paid to Dr. Colin Ferguson since July 1st, 1952, to run for 12 months.

The balance on hand in this Bank Account at September 30, 1952, was $1,167.55. With interest due to be received this account can carry the 9 payments of $150.00 per month and have a working cash balance on hand without cashing in any bonds. Any further scholarship grant of comparable size before this is completed will necessitate sale of bonds.

Investment Trust Account

There have been no bonds purchased or sold in this account during the past year and the bonds in the bank amount to $60,000.00.

Receipts

Cash on hand at Oct. 1, 1951	$1,978.64
Interest received from Bonds and bank balances	1,820.68
Total	$3,799.32

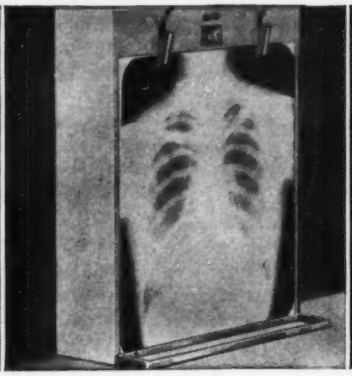
Disbursements

Medical College Library Grant annual	$ 750.00
Medical College Library Grant supplementary	250.00
Purchase of furniture	219.00
Purchase of typewriter	209.25
Extra-mural expenses	416.10
Total	$1,844.35
Balance on hand at Sept. 30, 1952	$1,954.97

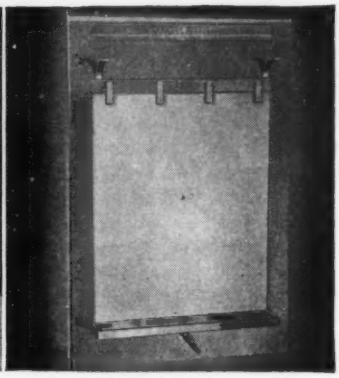
This shows a net loss in this account of $23.67 due to furniture investment and heavier Extra-mural expense payments which your treasurer considers a good investment of these earnings.

There's a GE viewer just right for you!

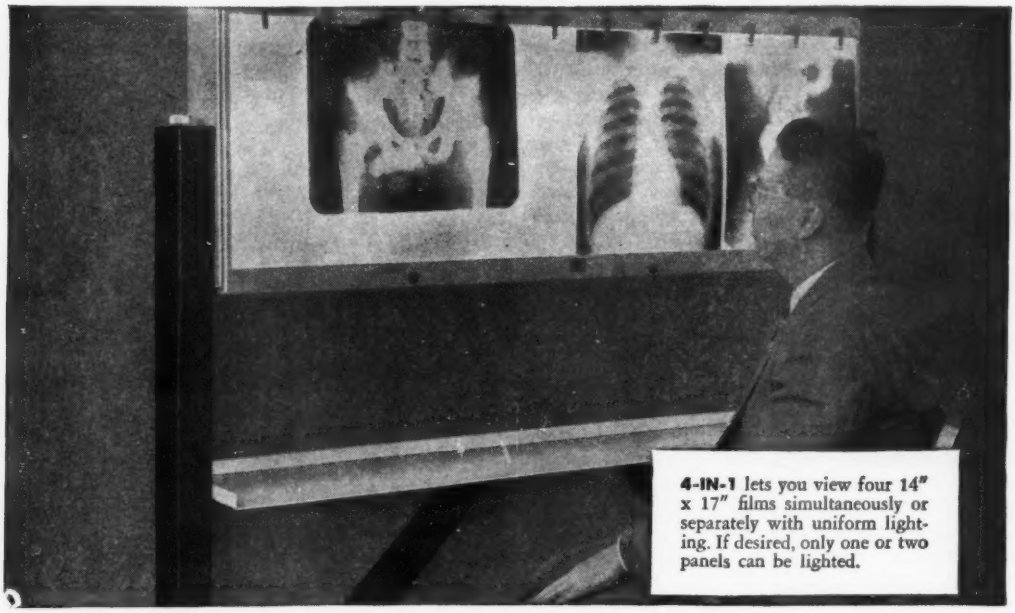
CIRCLINE — the best illuminator for general use. Named for the famous GE Circline Lamp that furnishes its top-notch, uniform illumination.



DUOLINE — a lighter, less expensive unit, yet with excellent illumination from two straight General Electric fluorescent lamps.



EXPLOSION-PROOF for operating rooms. Stainless steel throughout and, like the other GE illuminators shown, U/L approved.



4-IN-1 lets you view four 14" x 17" films simultaneously or separately with uniform lighting. If desired, only one or two panels can be lighted.

Yes, GE builds illuminators of every type. In addition to the four shown here, you can choose from 70 mm single-frame and stereo viewers . . . 4" x 5" and 4" x 10" single and orthostereoscopic viewers . . . GE High-Intensity viewers . . . dental viewers. For complete information, see your nearest GE x-ray representative, or write

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Current Account

Total revenue in this account for the year amounted to $14,385.38 and total disbursements for current expenses to $13,308.65 showing an excess of revenue over disbursements of $1,076.73.

A great part of our income continues to come from registrations to practice and many of these come from those who do not intend to practise in Manitoba. So far the revenue from this source has sufficed to cover the extra help needed except that we had to buy furniture and typewriter out of Investment Trust balances on hand. Should this source of income dry up or decrease our office salaries and expenses at present costs cannot be borne from other sources of income.

During the year there has been some consultation and consideration given to the investment of reserve funds in property or other securities which would return more than 3% income. Considerable time was spent in going over the Apex Building, but the committee unanimously decided it would not be suitable at the price demanded. It is hoped a suitable buy may be found for office accommodation and other desirable facilities for the College use.

The question of selling some of our 3% bonds and re-investing them in other bonds allowed by our Medical Act specifications was also taken up by the Finance Committee. However, though our bonds will be worth 100% of face value at maturity and will continue to pay us 3% in the interval, it would require approximately 7 years before the added interest would make up for the loss of face value at today's selling price of these bonds. It was consequently not considered wise to make this move. However, the question of some change in the Medical Act articles 89 and 90 to enable us to invest in more profitable and yet secure investments is being taken up with our solicitor. Security of investment must remain a paramount consideration.

Since the correspondence and office work required to answer inquiries and make arrangements for entitlement to registration for those who are coming from abroad have forced us to add to our office staff, equipment and space, it has been proposed to charge these enquirers a fee for documentation. The notice of motion requires this from any registrants "except those graduating in Manitoba" to pay a $25.00 "documentation" fee. It appears we may wisely modify this a bit because of the Medical Council of Canada and the fee to be charged only for those graduating outside Canada and who have not the right to reciprocal registration from the General Medical Council of Great Britain.

Your Treasurer is pleased to have come through the year without a deficit. This is in spite of rising costs of office help due to increased work load. He would point out to you that with the present staff expense we will face a deficit if registrations slump to a more normal level. It is therefore necessary that we protect our solvency by such means as may be at our disposal including "documentation fee" and legislation to allow of raising our fees if and when it becomes necessary.

Respectfully submitted
T. H. Williams, M.D., C.M.,
Treasurer.

PRICE WATERHOUSE & COMPANY
Toronto General Trusts Building
WINNIPEG

October 9th, 1952.

The College of Physicians and Surgeons
of Manitoba,
Winnipeg, Manitoba.

Dear Sirs:

In accordance with the instructions of your Registrar, we have made an examination of the books and records of the College of Physicians and Surgeons of Manitoba for the year ended September 30, 1952, and for your information we submit the following statements:

Gordon Bell Memorial Fund

Statement of the Fund—September 30, 1952	Exhibit I
Statement of Changes in the Fund during the year ended September 30, 1952	Exhibit IA
Statement of Cash Receipts and Disbursements for the year ended September 30, 1952	Exhibit IB

The Investment Account

Statement of the Fund—September 30, 1952	Exhibit II
Statement of Changes in the Fund during the year ended September 30, 1952	Exhibit IIA
Statement of Cash Receipts and Disbursements for the year ended September 30, 1952	Exhibit IIB

Current Account

Summary of Cash Receipts and Disbursements for the year ended September 30, 1952	Exhibit III
Statement of Cash Receipts for the year ended September 30, 1952	Exhibit IIIA
Statement of Cash Disbursements for the year ended September 30, 1952	Exhibit IIIB

In connection with these statements and our examination of the records we would offer the following comments:

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I-SO-GEL contains no purgatives and is a purely natural laxative with a smooth, mechanical action, especially suitable for the constipation of diabetes.

It is valuable also in mucous colitis, dysentery, haemorrhoids, and intestinal flatulence. After the performance of colostomy, I-SO-GEL gives excellent results by solidifying the faeces.

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Government of Canada Bonds

We attend at the safety deposit vaults of the Bank of Toronto on October 1, 1952, and, in conjunction with Dr. T. H. Williams and Dr. M. T. Macfarland, examined the Government of Canada bonds of a par value of $25,500.00 as shown under the heading of Gordon Bell Memorial Fund and bonds of a par value of $60,000.00 as shown under the heading of Investment Account. All of the bonds examined by us were seen to be fully registered in the name of the College of Physicians and Surgeons of Manitoba.

Funds on Deposit

The balances on deposit with the Bank of Toronto at September 30, 1952, in the two savings accounts and the current account have been reconciled with a certificate received by us direct from the bank.

Receipts and Disbursements

With the exception of the funds on deposit in the current account, which account is non-interest bearing, we have seen that interest has been received on all investments and funds. In the case of the current account we have checked the stubs of receipts issued by the Registrar in connection with registration fees, certificates, annual fees, etc., against the book entries. As a test to ascertain that annual fees received had been properly accounted for we traced the amounts shown in the cash book to the official lists of all members prepared by the College as at September 30, 1952, and at the same time listed any fees which were in arrears as at September 30, 1952; this list of arrears was agreed with a memorandum record maintained by your Registrar.

In regard to payments from Gordon Bell Memorial Fund and the Investment Account, we have examined bank advices, minutes and approved vouchers.

With regard to disbursements from the current account we have examined the paid cheques and relative approved vouchers in respect of the items appearing in the books. As the statements submitted relate only to cash receipts and disbursements, we have not gone into the question of any arrears in respect of fees or liabilities outstanding as at September 30, 1952, except to the extent mentioned previously in this report in regard to fees.

The following salary increases, effective Jan. 1, 1952, were granted in accordance with a Council resolution dated October 13, 1951:

Registrar	$400.00 per annum
Assistant to the Registrar	120.00 per annum

Payments to the Manitoba Medical Association include stenographic salaries aggregating $1,362.50. Of this amount the salary paid to Miss L. Zawadski totalling $730.00 has not been approved by a Council resolution.

With reference to incoming cash we would mention that remittances accompanying applications for enabling certificates, etc., are often not deposited in the bank for several months. We understand the reason for the delay is that the applicants' documents, etc., must be investigated before enabling certificates are issued and this process often takes considerable time. We would recommend that all such remittances be deposited regularly and that the amounts be credited to a suspense account in the books until the disposition of such items is determined.

We shall be pleased to furnish you with any additional information you may desire in regard to the attached accounts.

Yours very truly

(Signed) Price, Waterhouse & Co.

Exhibit I

The College of Physicians and Surgeons of Manitoba
Gordon Bell Memorial Fund
Statement of the Fund, September 30, 1952

INVESTMENTS

Government of Canada bonds fully registered in the name of The College of Physicians and Surgeons of Manitoba and carried at par:		
3 per cent Victory loan due 1957, 1 bond of $1,000.00 numbered L4 M39923	$ 1,000.00	
3 per cent Victory loan due 1966, 4 bonds of $5,000.00 each numbered P7 V14618-19-20-21, 3 bonds of $1,000.00 each numbered P7 M56243, M129375-6 and 3 bonds of $500.00 each numbered P7 Z73629, Z86255 and Z87584	24,500.00	
		$25,500.00
Funds on deposit with The Bank of Toronto, per Exhibit IB		1,167.55
Amount of the fund, September 30, 1952, per Exhibit IA		$26,667.55

Exhibit IA

The College of Physicians and Surgeons of Manitoba
Gordon Bell Memorial Fund
Statement of Changes in the Fund
During the Year Ended September 30, 1952

Amount of the fund, October 1, 1951		$26,342.53
Add:		
Interest on bonds	$ 765.00	
Interest on funds on deposit with the Bank of Toronto	10.02	
		775.02
		$27,117.55
Deduct:		
Payments to Dr. Colin Ferguson on account of scholarship award		450.00
Amount of the fund, September 30, 1952, carried to Exhibit I		$26,667.55

Exhibit IB

The College of Physicians and Surgeons of Manitoba
Gordon Bell Memorial Fund
Statement of Cash Receipts and Disbursements
For the Year Ended September 30, 1952

Balance of uninvested funds, October 1, 1951		$ 842.53
CASH RECEIPTS		
Interest on bonds	$ 765.00	
Interest on uninvested funds	10.02	
		775.02
		$ 1,617.55
CASH DISBURSEMENTS		
Payments to Dr. Colin Ferguson on account of scholarship award		450.00
Uninvested funds, September 30, 1952, carried to Exhibit I		$ 1,167.55

Exhibit II

The College of Physicians and Surgeons of Manitoba
The Investment Account
Statement of the Fund, September 30, 1952

INVESTMENTS

Government of Canada bonds fully registered in the name of The College of Physicians and Surgeons of Manitoba and carried at par:		
3 per cent Victory loan due 1957, 1 bond of $500.00 numbered L4 Z45631	$ 500.00	
3 per cent Victory loan due 1959, 4 bonds of $10,000.00 each numbered L7 X04926-7-8-9 and 1 bond of $5,000 numbered L7 V05687	45,000.00	
3 per cent Victory loan due 1966, 1 bond of $5,000.00 numbered P7 V13695, 9 bonds of $1,000.00 each numbered P7 M103575-6-7, M129373-4, M152612-3-4-5 and 1 bond of $500.00 numbered P7 Z72097	14,500.00	
		$60,000.00
Funds on deposit with The Bank of Toronto, per Exhibit IIB		1,954.97
Amount of the fund, September 30, 1952, per Exhibit IIA		$61,954.97

Exhibit IIA

The College of Physicians and Surgeons of Manitoba
The Investment Account
Statement of Changes in the Fund
During the Year Ended September 30, 1952

Amount of the fund, October 1, 1951		$61,978.64
Add:		
Interest on bonds	$ 1,800.00	
Interest on funds on deposit with The Bank of Toronto	20.68	
	1,820.68	
		$63,799.32
Deduct:		
Grant to medical library	$ 1,000.00	
Manitoba Medical Association, expenses of extra-mural lectures	416.10	
Office furniture and equipment	428.25	
	$ 1,844.35	
Amount of the fund, September 30, 1952, carried to Exhibit II		$61,954.97

Exhibit IIB

The College of Physicians and Surgeons of Manitoba
The Investment Account
Statement of Cash Receipts and Disbursements
For the Year Ended September 30, 1952

Balance of uninvested funds, October 1, 1951		$ 1,978.64
CASH RECEIPTS		
Interest on bonds	$ 1,800.00	
Interest on uninvested funds	20.68	
	1,820.68	
		$ 3,799.32
CASH DISBURSEMENTS		
Grant to medical library	$ 1,000.00	
Manitoba Medical Association, expenses of extra-mural lectures	416.10	
Office furniture and equipment	428.25	
	1,844.35	
Uninvested funds, September 30, 1952, carried to Exhibit II		$ 1,954.97

Exhibit III

The College of Physicians and Surgeons of Manitoba
Current Account
Summary of Cash Receipts and Disbursements
For the Year Ended Septpember 30, 1952

Cash in The Bank of Toronto as per books, October 1, 1951	$ 4,285.11
Cash receipts, per Exhibit IIIA	14,385.38
	$18,670.49
Cash disbursements, per Exhibit IIIB	$13,308.65
Uninvested funds, September 30, 1952	$ 5,361.84

Details of Uninvested Funds as at September 30, 1952

Petty cash fund		$ 10.00
Cash in The Bank of Toronto:		
Balance as per bank statement	$ 5,682.33	
Deduct—Outstanding cheques	330.49	
Balance as per books		$ 5,351.84
		$ 5,361.84

Exhibit IIIA

The College of Physicians and Surgeons of Manitoba
Current Account
Statement of Cash Receipts
For the Year Ended September 30, 1952

Registration fees		$ 7,975.00
Temporary licenses		220.00
Certificates:		
M.C.C.	$ 1,035.00	
G.M.C.	50.00	
		1,085.00
Specialist registration fees		215.00
Documentation fees		500.00
Annual fees		3,879.00
Medical students registration fees		73.00
Sales of Mailing Lists		431.00
Miscellaneous income		7.38
Total receipts carried to Exhibit III		$14,385.38

Exhibit IIIB

The College of Physicians and Surgeons of Manitoba
Current Account
Statement of Cash Disbursements
For the Year Ended September 30, 1952

Salaries:		
Registrar—Dr. M. T. Macfarland	$ 3,499.98	
Treasurer—Dr. T. H. Williams	500.00	
Assistant to the Registrar—Miss J. Allison	2,215.00	
		$ 6,214.98
Meetings:		
Annual, October, 1951	$ 580.20	
Special, May, 1952	712.00	
Executive Committee	247.20	
Special Committees	341.80	
		1,881.20
Luncheon expenses—annual and special meetings		37.00
Legal fees		25.00
Amount paid to Manitoba Medical Association in respect of office rental and secretarial services, etc.		2,350.52
Janitor services—annual and special meetings		10.00
Auditors' fees		175.00
Insurance premiums		17.60
Printing, stationery and office supplies		1,770.36
Postage		258.47
Expenses of Registrar—re meeting in Banff		190.00
Miscellaneous office expense		92.37
General expenses		35.25
Exchange on cheques, etc.		15.90
Refund of portion of registration fee		90.00
Manitoba Medical Association re expense of The Workmen's Compensation Board Fee Taxing Committee		145.00
Total disbursements carried to Exhibit III		$13,308.65

Motion: "THAT the Treasurer's and Auditors' Reports be adopted." Carried.

ELECTRON MICROGRAPH
drawing of spirochetes (X18,720). Ring-form organisms occur following exposure to an antagonistic agent.

In Syphilis...

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"Penicillin alone far surpasses any previously used antisyphilitic remedy when appraised from the therapeutic, economic, technical, toxicity rate, or prophylactic aspects. And most important, its high index of therapeutic accomplishments is enhanced by the simplicity of administration and its availability."

Curtis, A.C., Kitchen, D.K., O'Leary, P.A., Rattner, H., Rein, C.R., Schoch, A.G., Shaffer, L.W., and Wile, U.J.: Penicillin Treatment of Syphilis, *J. A. M. A.* 145: 1223-1226, April 21, 1951.

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✻ **CODOPHEN PAEDIATRIC**
C.T. No. 259

Each tablet contains:

Acetylsalicylic Acid	3/8 gr.
Phenacetine	3/8 gr.
Caffeine Citrate	1/8 gr.
Codeine Phosphate	1/12 gr.

✻ **CODOPHEN C.T. No. 260**

Each tablet contains:

Acetylsalicylic Acid	3 gr.
Phenacetine	2 gr.
Caffeine Citrate	1/4 gr.
Codeine Phosphate	1/4 gr.

✻ **CODOPHEN STRONGER**
C.T. No. 260A

Each tablet contains:

Acetylsalicylic Acid	3 gr.
Phenacetine	2 gr.
Caffeine Citrate	1/4 gr.
Codeine Phosphate	1/2 gr.

✻ Narcotic Order Required. *Codophen tablets are orange coloured but are otherwise unmarked.*

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Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1952 Nov. 30 to Dec. 27,'52	1952 Dec.2 to Dec. 29,'51	1951 Nov. 2 to Nov. 29,'52	1951 Nov. 4 to Dec. 1,'51	Total Jan. 1 to Dec. 27,'52	Total Jan. 1 to Dec. 29,'51
Anterior Poliomyelitis	23	3	89	3	780	54
Chickenpox	233	190	192	231	1561	1815
Diphtheria	0	0	0	1	2	6
Diarrhoea and Enteritis, under 1 yr.	17	5	14	12	158	168
Diphtheria Carriers	0	0	0	0	0	1
Dysentery—Amoebic	0	0	0	0	0	0
Dysentery—Bacillary	4	2	4	0	29	27
Erysipelas	3	1	2	4	18	32
Encephalitis	0	0	0	0	5	4
Influenza	9	5	6	8	155	792
Measles	468	127	388	93	2162	3105
Measles—German	1	3	1	2	15	47
Meningococcal Meningitis	1	0	2	1	16	38
Mumps	102	165	137	145	1391	1677
Ophthalmia Neonatorum	0	0	0	2	1	4
Puerperal Fever	0	0	0	0	2	1
Scarlet Fever	47	82	46	94	650	1329
Septic Sore Throat	2	3	4	14	77	46
Smallpox	0	0	0	0	0	0
Tetanus	0	0	0	0	4	1
Trachoma	0	0	0	0	0	0
Tuberculosis	56	0	101	83	868	1003
Typhoid Fever	0	0	0	2	5	5
Typhoid Paratyphoid	0	0	0	0	2	0
Typhoid Carriers	0	0	0	0	0	0
Undulant Fever	0	0	1	1	5	12
Whooping Cough	10	58	14	84	416	636
Gonorrhoea	93	108	82	109	1291	1285
Syphilis	5	12	9	11	116	170
Infectious Jaundice	6	0	26	0	66	0
Tularemia	0	0	0	0	4	0
Actinomycosis	1	0	0	0	1	0

Four-Week Period November 30th to December 27th, 1952

DISEASES (White Cases Only) *Approximate population.	*776,541 Manitoba	*861,000 Saskatchewan	*3,625,000 Ontario	*2,953,000 Minnesota
Actinomycosis	1	1	...	...
Anterior Poliomyelitis	23	39	16	81
Chickenpox	233	222	2275	...
Diarrhoea and Enteritis, under 1 yr.	17	21	...	...
Diphtheria	...	...	4	...
Diphtheria Carriers	...	...	...	...
Dysentery—Amoebic	...	...	...	5
Dysentery—Bacillary	4	1	15	15
Encephalitis Epidemica	...	2	...	2
Erysipelas	3	...	1	...
Influenza	9	1	8	2
Infectious Jaundice	6	20	92	33
Malaria	...	...	...	3
Measles	468	162	1544	764
German Measles	1	49	105	...
Meningitis Meningococcus	1	2	6	7
Mumps	102	59	1242	...
Ophthalmia Neonatorum	...	...	...	...
Psittacosis	...	...	...	1
Puerperal Fever	...	...	...	...
Scarlet Fever	47	174	283	173
Septic Sore Throat	2	27	4	18
Smallpox Vaccine	...	...	...	...
Tetanus	...	...	...	...
Trachoma	...	...	...	...
Tularemia	...	...	...	...
Tuberculosis	56	22	111	149
Typhoid Fever	...	2	...	2
Typhoid Paratyphoid	...	...	...	...
Typhoid Carrier	...	...	...	...
Undulant Fever	...	...	1	...
Whooping Cough	10	23	78	12
Gonorrhoea	93	...	127	...
Syphilis	5	...	38	...

DEATHS FROM REPORTABLE DISEASES

For the Month of December, 1952

Urban—Cancer, 42; Influenza, 2; Pneumonia Lobar (490) 2; Pneumonia (other forms), 5; Tuberculosis, 2; Diarrhoea and Enteritis (under 2 years), 1; Meningococcal Infection, 1. Other deaths under 1 year, 29. Other deaths over 1 year, 204. Stillbirths, 14. Total, 247.

Rural—Cancer, 37; Influenza, 2; Measles, 1; Pneumonia Lobar (490), 5; Pneumonia (other forms), 6; Syphilis, 1; Tuberculosis, 6; Diarrhoea and Enteritis (under 2 years), 1; Dysentery, 2; Septicaemia, 1. Other deaths under 1 year, 19. Other deaths over 1 year, 178. Stillbirths, 14. Total, 211.

Indians—Measles, 1; Pneumonia (other forms), 1. Other deaths under 1 year, 2. Other deaths over 1 year, 3. Stillbirths, 0. Total 5.

♦

Considering communicable diseases the end of the year shows Manitoba in a favorable light excepting for poliomyelitis and even with it we were more fortunate than the other western provinces. Poliomyelitis cases reported at date of writing (January 14th) are nearly 800 and total deaths 27 (two occurring in 1952 cases but deaths in January, 1953).

Highlights are only two cases of diphtheria, five of typhoid, two of paratyphoid and no deaths among these.

Tuberculosis and Syphilis have both decreased considerably.

Infectious Jaundice, which was made notifiable one year ago, reports 66 cases and no doubt many others occurred.

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